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ABSTRACT

The collection of program summaries is organized according to the six primary program categories represented in Continuing Education Training Programs: (1) physicians, (2) psychiatrists, (3) behavioral scientists and allied professionals, (4) nurses and related personnel, (5) social workers and related personnel, and (6) interdisciplinary training. The summaries are presented in alphabetical order, by institution or organization, within each of these major categories. Each summary provides the name of the project director, the name and address of the sponsoring organization, the National Institute of Mental Health training grant number, and the span of years during which grants were awarded by the continuing education branch. Each summary describes the program's objectives, background, content, trends, objectives, participants, and an evaluation. (MW)

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CONTINUING EDUCATION IN MENTAL HEALTH

Project Summaries

Edited by Staff of
Continuing Education Branch
Division of Manpower and Training Programs

National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20852

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PREFACE

The Continuing Education Training Branch of the Division of Manpower and Training Programs, National Institute of Mental Health, was established in 1966 with the objective of planning, administering and coordinating a national program of training grant support in continuing education, staff development and adult education. Its overall purpose is to provide better mental health services to people by expanding the knowledge and skills of personnel working in mental health and related delivery systems.

In the years since the inception of the program many requests have been received from the field for greater dissemination of information concerning continuing education programs, particularly on such aspects as training design, methodology and training techniques, types of trainees, evaluation, and institutions and agencies involved.

In order to respond to these requests the Continuing Education Branch undertook a staff project to compile this information from summaries submitted by NIMH supported programs. In the fall of 1972, a letter was sent to each of the NIMH funded Continuing Education Project Directors, requesting a summary of each continuing education program in operation during 1972–73, for inclusion in a publication.

Arbitrary conclusions cannot necessarily be drawn from these summaries, but it seems apparent that as Federal support of mental health continuing education has decreased, State and local governments and employers and the trainees themselves, in many areas, have undertaken a greater proportional share of training costs. On the other hand, nearly one-half of the summaries stated that the sponsoring institution did not plan to provide support after termination of the present training grant. This gives food for thought if it truly reflects the future of continuing education vis-a-vis total Federal support and institutional capacity and willingness to support such programs.

We believe that the future will see an expansion of Continuing Education, with more State and local government involvement in concert with institutions of higher education. It is hoped that this handbook will be of help to those who in the future will be planning and operating continuing education programs.

We are indebted to the continuing education program directors who willingly responded to the questionnaire, giving an overview of their training program, and who in doing so shared their impressions and feelings with others.

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Chief, Continuing Education Branch
MRS. JEANETTE G. CHAMBERLAIN,
Chief, Nursing and Related
Therapeutic Personnel Section
MR. RICHARD J. LOEBL
Social Science Analyst

CONTENT ORGANIZATION

The summaries presented in this book were prepared by the Continuing Education Project directors with minimal editing by NIMH personnel. The project directors were asked to respond to a survey with questions pertaining to major aspects of their programs, a copy of which may be found in appendix A ("Overview of Training Program").

The content is organized according to the six primary program categories represented in Continuing Education Training Programs. The summaries are presented in alphabetical order, by institution or organization, within each of these major categories. Below the title of each summary is the name of the project director, the name and address of the sponsoring organization, the NIMH training grant number, and the span of years during which grants were awarded by the Continuing Education Branch.

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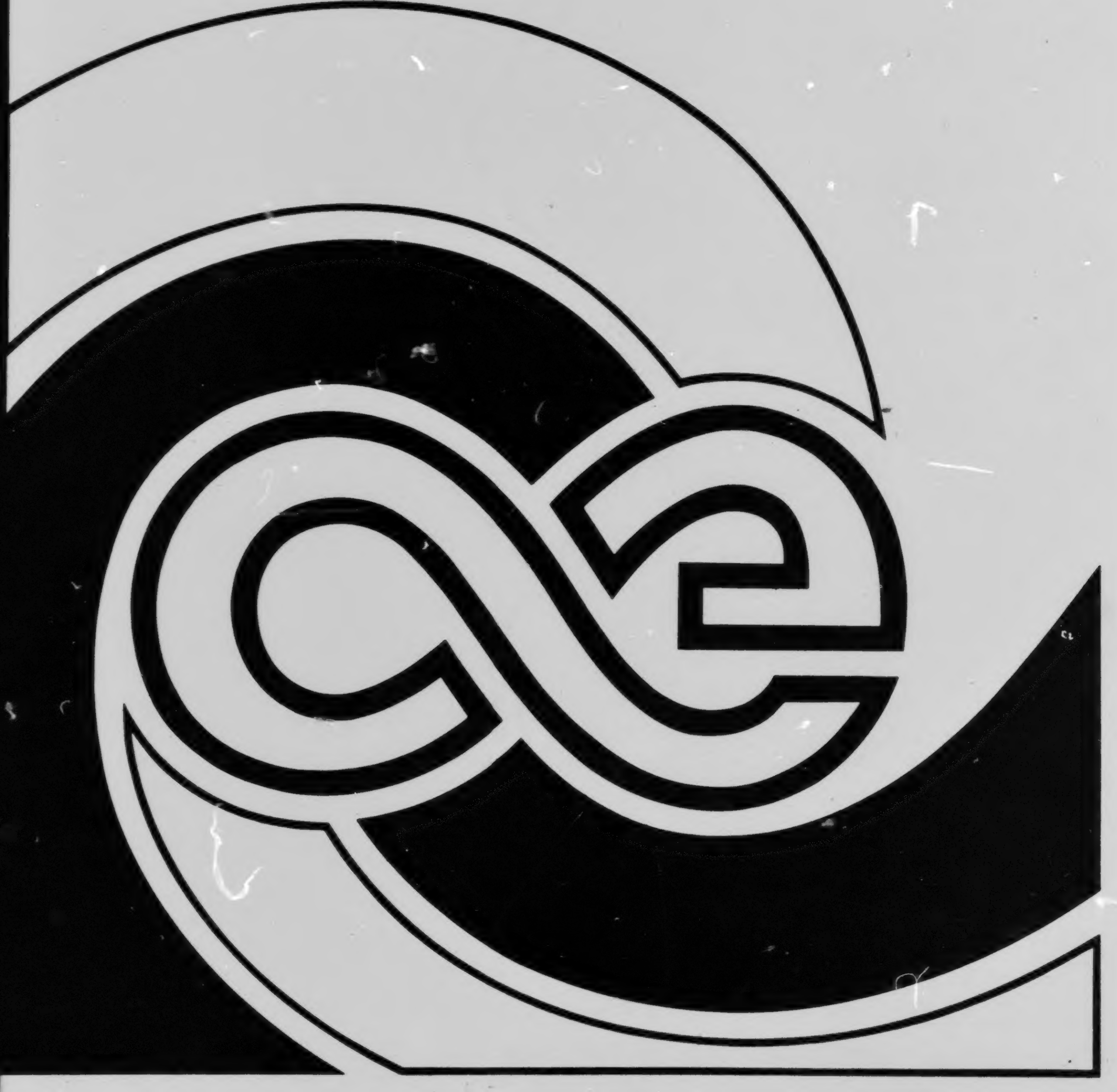
PART 1

CONTINUING EDUCATION FOR PHYSICIANS



Conduct and Evaluation of Psychiatric Education

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MH07929 1962–1974

Objectives

The Albany Medical College plans to continue a 10-year program of postgraduate psychiatric education carried on by the Department of Psychiatry. This program is aimed primarily at the nonpsychiatric physicians of the region served by the Albany Medical Center, in north and east interior New York and adjacent areas of Vermont, Massachusetts, and Connecticut; and secondarily at a more extended area served by other centers of medical learning by means of the Albany Two-Way Radio Program.

The College also plans to evaluate teaching methods used in the program in the past and present; to review the suitability and published evaluation of teaching methods not being used in this program, to terminate methods of low or questionable value, and introduce new programs in their stead, whether of reputed value or innovative promise.

The scope of the target population will be expanded, first to involve a greater number of physicians, secondly to involve them to a more significant degree and finally to include members of other health professions who can assist the physician to carry out his responsibility for his patient's mental health and emotional well-being.

Specifically, the program plans to increase the sensitivity of physicians to psychological aspects of patient management. An important challenge exists where a physician knows of the psychological aspects of an illness, yet apparently fails to take it into account. The goal of the program is to further the concept of a psychological aspect of all disease.

The individual physician will be faced from time to time with a psychiatric emergency. There is a basic list of such crises which any physician might encounter and for which he should be prepared to give first aid. It is the intention of this program, in cooperation with the other Medical Colleges of New York State, to offer programs to meet the training needs of physicians in these emergencies.

Methods and Content

The Annual Teaching Day Program: The morning is given over to basic science of a particular topic, e.g., psychopharmacology. The afternoon sessions are used for practical clinical teaching. Small group seminar teaching with liberal use of visual aids, especially videotape, are used. A keynote speaker of national reputation is featured in each of the programs. The topic for next years' Teaching Day is "Human Sexuality and the Medical Practitioner."

Workshops on particular topics are organized at outlying centers, corresponding to the needs expressed by the local professionals. These are not confined to physicians but are aimed at the local health care team. Seventeen such workshops were held in the past year, with attendance exceeding 300.

Programs are broadcast on the Albany Medical College FM radio station reaching the Albany, St. Lawrence, and New York City areas. These programs reach over 3,000 physicians annually, and a two-way radio question and answer feature had 190 physicians registered for the most recent of these programs in 10 community hospitals.

Medical and Psychiatric Seminars: These are arranged on specific topics and held in conjunction with other organizations. They include a medical seminar cruise (not grant-supported), an Institute on Family Therapy, a Seminar on Youth, and one on Recent Advances in Psychiatry, all annual, and occur at intervals throughout the year. Course hours vary between 6 and 14.

Students

This program is primarily aimed at nonpsychiatric physicians, of whom more than 250 registered last year. Also, over 400 other mental health workers, psychologists, social workers and psychiatric nurses attended programs, particularly workshops and the seminars on Youth and Family Therapy respectively.

Program Evaluation

The decisionmaking process is the overall responsibility of Dr. Alan Kraft, chairman of the Department of Psychiatry. He appoints a chairman of Postgraduate Psychiatry Committee which meets at least monthly under the chairmanship of Dr. Irving Dribben, former director of the grant project. This is a group of mostly physicians, with representation from the Capital District Consortium of Departments of Psychiatry, the Academy of Family Practice, private practitioners and Albany Medical College Department of Postgraduate Medicine.

The executive director of the program is Dr. Raymond Vickers, a psychiatrist and internist who spends half time on the program and half time in his subspecialty of geriatrics. All programs have ad hoc program committees of their own, and the coordinator (usually chairman) of each program committee is a member of the P.G.P. Committee.

Programs are evaluated by questionnaire, and reports are made to the committee, which recommends and assists in the planning of each program. This results in some delay in introducing innovative concepts but this is more than compensated by the accumulated experience of the group and its value in disseminating information concerning the program.

Psychiatry–GP–Postgraduate Education

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MH08044 1969–1973

Objectives

The general objective of this training program is to further the continuing psychiatric education of the American family physician to improve and expedite the quality of psychiatric treatment received by the public. In other words, to help the nonpsychiatric primary care physician evolve as a pertinent and necessary component of the existing psychiatric health care system.

The trainee target groups are primarily the 33,000 members (approximately 50 percent of all family physicians) of the American Academy of Family Physicians. Originally, the specific objectives were to (1) provide the family physician with a basic understanding of psychiatric principles; (2) increase his awareness of the symptoms of emotional disorder; and (3) orient him to the nature and extent of facilities, personnel and information available in the treatment of emotional illness.

To strengthen and improve the committee function, specific goals for future programs are: (1) to educate the family physician to better attend to his own mental health; (2) to develop programs to educate the family physician about the medical/psychiatric problems common to various subcultures within our society (e.g., blacks, Indians, Mexican-Americans, women, etc.); (3) develop programs to increase the family physician's understanding of the total human reaction to the effect of a disease state, whether mental or physical; (4) continued utilization of programs emphasizing basic principles in areas where more programs would be useful.

Methods and Content

The country has been divided into nine geographic regions with a member of the Academy's Committee on Mental Health in charge of supervising the programs in each area. Workshops have been held in these regions to train the key personnel who will be conducting the continuing psychiatric education courses for the family physician. Consultants from the fields of psychology and sociology have been called upon to help the physicians teach their programs. Most of the courses are conducted as seminars with a great deal of group discussion. This method was found to be particularly effective when dealing with the problems of psychiatric illness. One of the most valuable programs was that of the Menninger Foundation Seminars conducted by the Menninger staff. To date, three Menninger Seminars have been held reaching many Academy members. The experience has proved invaluable to the individual family physician and, therefore, to his patients.

From the Menninger model, many local programs have been developed by various State mental health committees. These seminars combined two methods of teaching-lectures and small group discussion. In other programs, many sociological and psychological factors have been brought into the "learning circle" such as the presence of the physician's wife and family. Video tapes have also been used in describing patient-physician interviews. The tapes have been found to be very effective teaching methods. They are particularly useful because they are easily transported and may reach many physicians at one time.

Proposed training programs would be specifically concerned with teaching the family physician, general practitioner, resident in family practice and intern to be aware of and treat the psychological as well as the physical aspects of a disease state. Using the methods described above, various topics related to these problems will be discussed throughout the country. In 1972, during a conference on behavioral sciences, 10 common disease states were assigned to family practice residencies for study. The emphasis was to be placed on the psychological effects of these disease states.

The proposed programs for training the family physician in this field will vary according to the geographic region in which he is living. In the past, many of the programs have been weekend retreats such as the Pennsylvania program, "What You've Always Wanted To Know About Doctoring But Were Afraid To Ask!" Others have lasted for a week or more (the Menninger Foundation Seminars). Therefore, it is difficult to state exactly how many course hours will be taken by each family physician. However, because postgraduate continuing education is required of every Academy member, all of the family physicians involved will be spending some time in psychiatric education courses each year.

Students

The majority of trainees who will benefit from the program are all family physicians. These physicians either have their own practice or are residents or interns. However, some paramedical professionals (psychologists, sociologists or anthropologists) will also participate in these programs. It is estimated that 150 key State physicians will be involved in the regional programs. An average of 75 local physicians will participate in the State programs.

All of the physician trainees have graduated from an AMA approved medical school and most of them are members of the AAFP. The population of the potential trainees is 3,900 physicians with many others involved in derivative programs.

Program Evaluation

This type of program is more easily "assessed" rather than strictly "evaluated." The primary reason for this is that the programs are dealing with intangible concepts which are not subject to statistical evaluation. Therefore, it is felt that the methods of evaluation must be kept quite flexible. The data that is gathered will be presented to an evaluation/utilization committee, which, together with the administrator of the entire educational program, will establish the program's effectiveness. Most of this data will be collected from the program participants, i.e., family physicians. The Academy's national office has much background material on all of the participants in these programs because most of them will be AAFP members.

The specific methods used will be that of short, open-ended questionnaires which will be sent to all of the various program participants. These questionnaires and other evaluation methods will be examined and reprocessed with the help of the Menninger Foundation Research Department.

The potential for replication of these programs at the local, regional and national levels is extremely high. Many of the current programs have been developed as a result of educational lectures and seminars funded through the NIMH grant. One good example of this is the Menninger Foundation seminar.

Many of the objectives of the program were incorporated into the Pennsylvania State Steering Committee course entitled "What You've Always Wanted To Know About Doctoring But Were Afraid To Ask!" The physicians were asked to bring their wives and families so that they could gain a better understanding of their own mental health and how their personal problems may affect the treatment they administer to their patients. Every year more new programs are proposed. All of these that can be funded are carried out and usually received enthusiastically. Therefore, it appears that replications of these programs are being used at all levels.

The major strengths of the project are that: (1) through these educational programs, family physicians will be made aware of and given better methods for delivering the most complete and comprehensive medical care to the public; (2) family physicians will be given more information about the behavioral sciences and how knowledge of these subjects may be incorporated into the treatment of their patients; to bring about not only better medical care but also improved psychological treatment; (3) the family physician will be made aware of the sources present in his community for treating or helping patients with psychological problems; (4) research/evaluation methods and samplings will be conducted with the professional help of the Menninger Foundation Research Department; and (5) the total design of the administration of the program at the national, regional and local levels has been revised to be more efficient.

The major weaknesses of this project are that: (1) there are so many educational programs available for physicians that programs must be designed with a common appeal; and (2) it is often difficult to make family physicians, or any medically oriented personnel aware of the importance of psychological factors which may be related to disease states.

The programs which are developed through this project will be constantly reminding the family physician that he has an obligation to his patients to treat their "entire" problem. This means that he will be made aware of the psychological as well as the physical factors that contribute to the disease state. This will hopefully engender better medical care for the American public. The physician will be urged to realize psychological problems that may be affecting himself and, therefore, his practice. These concepts have long been overlooked by many physicians. Because of the importance of these factors and their obvious relation to improved health care, the program considers its approach innovative to continuing education in the field of mental health.

Psychiatry–Physician Education Project

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MH07269 1960–1975

Background and Objectives

From 1960–1970, this project succeeded in developing a nationwide program in continuing education in psychiatry for primary physicians. In the late 60's, the project emphasis was shifted from traditional program development to improving program quality; developing leadership and educational skills; and increasing individual and institutional commitment to continuing education. The decisionmaking process for all aspects of this program has been a collaborative one involving the funding agency, advisory groups and the participants. The program's advisors include management consultants, social psychologists, clergy, general physicians, and psychiatrists.

The general objectives of the training program are: (1) to develop the educational skills of teachers in continuing education in psychiatry and behavioral sciences for primary physicians; (2) to expose teachers to new content areas of high social priority in the mental health field; and (3) to gain acceptance and support among major physician groups for continuing education in psychiatry.

Specific objectives include the following: (1) to test, refine, and replicate innovative educational techniques that can change behavior and attitudes as well as add knowledge; (2) to increase teachers' commitment of time, effort, and enthusiasm to continuing education; (3) to develop a national organization that will sanction innovation in continuing education, and provide ongoing educational, consultative support for teachers and program directors; (4) to help teachers relate their programs to broad, general health issues and rapid social change.

Methods and Content

The general and specific objectives of the project are achieved through a network sustained by consultation among its members and by periodic meetings designed to: (1) develop and refine the kinds of relationships that lead to program cross-fertilization; (2)

serve as an arena for exchanging and sanctioning innovative educational techniques, including the use of audiovisual technology, simulations, role playing, games, sensitivity techniques, group dynamics, program design, curriculum development and evaluation by student participants; and (3) be a laboratory for experimenting with and refining these techniques.

To increase institutional support for continuing education in psychiatry, the program works closely with individuals and liaison committees of the American Psychiatric Association, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, the American Medical Association, the Association of American Medical Colleges and the Society for Teachers of Family Medicine. These groups are invited to participate in the annual Colloquium for the Postgraduate Teaching of Psychiatry.

To integrate these two strategies of Network development and institutional development, the program has invited representatives from various medical organizations to participate in its activities, and, through that exposure, to introduce new techniques tested in the meetings into the educational programs of their parent organizations.

The primary focus of the program is on the process of learning, its relationship to changing values, interpersonal and group behavior, and psychiatric skills. Content areas dealt with include such topics as sex, death, the family, drug abuse, alcoholism, interdisciplinary collaboration, community organization, and value conflicts between generations, sexes and races. In presenting these important "content" issues, the program stresses not only the experience of the patient, but also the reaction of the doctor.

Students

The participants in this program are experienced program directors and teachers. Most participants are actively teaching psychiatry to primary physicians; but representatives from other mental health and behavioral science specialties are included to broaden and enrich the program. In anticipation of increasing demands for an interdisciplinary program, program directors with broad interdisciplinary experience also are being included.

Program Evaluation

Evaluation guidelines were established at the outset, with advice from consultants in industry, psychology, health administration, and information processing. The guidelines stress these elements: (1) document the replication of the program's educational techniques in other training programs; (2) demonstrate participants' acquired ability to design and lead educational activities for fellow participants; (3) identify the use of participants as consultants by other program directors, evidencing their recognition as experts; (4) gather information relating to the four specific objectives of the training program, e.g., through semistructured interviews with program directors; (5) test by questionnaire the value of introducing experiential techniques into traditional meetings; (6) explore by structured interview the ability of the program to meet the original and evolving educational needs of participants.

The potential for the replication of aspects of this program nationally, regionally, statewide, and locally, is evidenced by the following developments:

- the alteration of the format of the annual Colloquium to include experience-based learning;
- agreement by the American Association of Family Physician's Committee on Mental Health to cosponsor a Colloquium in March 1973, in an effort to induce more family practitioners to continue education in psychiatry for primary physicians;
- the accreditation of the annual Colloquium by the AMA;
- the successful offering of a course in experiential learning at the AMA Annual Meeting in June 1972;
- inclusion of experience-based learning techniques by the SREB and WICHE in their Teacher-Training Institutes for program directors; and
- identification of at least 40 instances of the use of this program's techniques in statewide or metropolitan programs in 15 States.

The major strengths of this program are its flexibility; the variety of points of view represented by participants and consultants; a climate that encourages educational experimentation and innovation; the administrative framework of personal involvement that fosters a uniquely intense trust between participants; the productive blurring of distinctions between "faculty" and "students"; and the excitement infused into the work of participants.

Psychiatry–GP–Postgraduate Education

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MH10271 1965–1973

Background and Objectives

The University of Arkansas Medical Center is presently expanding its existing program of continuing education for nonpsychiatric physicians, of 7 years' duration, to include multidisciplinary participants. Therefore, the multisponsored Steering Committee for postgraduate training of the nonpsychiatric physicians has been altered to a Multidisciplinary Advisory Committee. Disciplines represented on this Advisory Committee include nursing, social work, ministry, psychology, law, and the nonpsychiatric physician. This Multidisciplinary Advisory Committee, along with the Program Director and the other consultants, is responsible for the decisionmaking process in planning and implementing the continuing education program.

The first general objective is to help the multidisciplinary participants in the program develop increased sensitivity and understanding of recognition, management, treatment, and prevention of emotional and mental health problems that invariably confront them in their daily interpersonal dealings with patients, clients, and parishioners. This allays their personal anxiety and increases their effectiveness when dealing with the psychological aspects of the population being served.

The second general objective is development of effective interdisciplinary communication by the course participants. Development of these skills within the structured supportive educational program enables the participants to transfer these skills to their everyday work situations, therefore, increasing the availability of optimal mental health care for the citizens of Arkansas.

More detailed specific objectives are as follows: (1) to supply additional information to the multidisciplinary course participants in the areas of emotional and mental health problems; (2) to further increase the ability of the multidisciplinary participants to recognize and prevent emotional and mental health problems; (3) to further increase the ability of the multidisciplinary participants to manage and treat emotional and mental health problems; (4) to further increase the understanding and appreciation of the course participants of the abilities and contributions of each discipline; and (5) to further increase the ability of each course participant to function effectively within a multidisciplinary group.

Methods and Content

The Basic program consists of topic oriented seminars utilizing lectures, general discussion, demonstration interviews, audio and video tapes, films, assigned readings, and subject oriented multidisciplinary interactional small groups. The Regional program is the same as the Basic program except it is conducted in outlying areas of the State. The Advanced program is a case oriented, small group discussion seminar utilizing interviews with participants' problem cases. Interviews are videotaped and played back for analysis and critique by participants and instructors.

The following content areas are presented; applied psychodynamics, drug therapy in mental and emotional disorders, psychiatric emergencies and crises, marital counseling, depression and suicidal risk, emotional disorders in childhood, adolescent behavioral problems, care of the geriatric patient, the dying patient, alcoholism, drug abuse, psychosomatic conditions, techniques of short-term psychiatric treatment, and additional content that the participants request.

The Basic program meets on alternate weeks for 14, 3-hour sessions during an approximate 9-month period for a total of 42 hours. The Regional program meets monthly for a 3-hour session, six times for a total of 18 hours. The Advanced program meets weekly for 25 2-hour sessions during an approximate 9 month period for a total of 50 hours.

Students

The Basic program this year has 34 students in the following categories: there are eight participants from the discipline of nursing, three social workers, ten nonpsychiatric physicians, seven ministers, two lawyers, two psychologists, and two speech pathologists. The Advanced program has the following participants: seven nonpsychiatric physicians and two social workers.

It is significant that the programs are multidisciplinary this year. With this change the target population of potential trainees includes a majority of the practitioners in the above disciplines in Arkansas.

Program Evaluation

Program evaluation will include attendance records and subjective evaluation of program by multidisciplinary students and faculty. Program students and faculty contribute to the ongoing evaluation of the program. Future evaluation plans include a possible attitudinal evaluation and a follow-up interview 6 months following the program with individual students.

The unique aspect of this program is the involvement of various professions in the same learning situation with the opportunity to increase multidisciplinary communications. There is a great potential for a similar multidisciplinary program at local, regional, and national levels with the focus on increasing communication and giving information in a multidisciplinary setting.

The program for nonpsychiatric physicians that has existed for 7 years is felt to be having a great impact in many communities in Arkansas. It is felt that this impact on local communities throughout the State will increase because of the increased number of participants now involved in the program.

The most recent training renewal grant application that has been submitted is for a multidisciplinary program. This year the program is beginning to work with a multidisciplinary group. This change has followed the program's success in working with nonpsychiatric physicians and the expressed need from professionals for a similar type of content and the expressed need to be able to work more effectively with health professionals.

The major strengths of the program have already been enumerated, e.g., accepting participants at their own level of learning in program planning, information needs, increasing interactional skills and evaluation. The major weakness, because of the increased number of program participants, is the lack of a full-time program coordinator for planning, implementation and evaluation.

Psychiatry–GP–Postgraduate Education

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MH07156 1959–1973

Objectives

Since April 1959, when a grant was first awarded by the National Institute of Mental Health, this program, with modifications, has continued to provide to nonpsychiatric physicians on the staff of the Beth Israel Hospital opportunities to understand the psychological components accompanying physical illness, and to integrate this knowledge into the general and special practice of medicine. There have been alterations in the conceptualization of how the end results were to be reached, and activities have been added and deleted with the passage of time, but the goal of having the patient viewed as a person and not as a disease or accumulation of laboratory results has persisted. With the technological advance towards computerized medicine which threatens to remove even further the personal interaction between the physician and the individual seeking help, that goal has become imperative.

Methods and Content

In the earlier years, in addition to occasional case conferences or patient inter-

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views conducted by the psychiatrist in the presence of the trainees, the major vehicle of instruction was the weekly or fortnightly seminar lasting from 1 to 2 hours. These seminars offered an opportunity to learn about psychodynamic and psychoanalytic theory, often in relation to the challenging clinical situations that were reported at the sessions. In some instances a more formal presentation of the theory of personality, defense mechanisms, depression and similar topics was made.

Over the years, there has been a shift from trying to impart to the trainee the skills and knowledge of the theory of psychotherapy so that he himself could administer it to some degree, to an emphasis on the demonstration of the investigative clinical interview geared toward the uncovering of the patient's feelings about his illness, its origins, significance and consequences. Emphasis also has shifted to a demonstration of how these factors are best taken into account by the physician, ward personnel, family members and community facilities.

A staff psychiatrist and psychiatric resident have been assigned to each of the medical wards, the obstetrics-gynecology service, the intensive care units and the ward housing orthopedic and neurologic patients. The psychiatric personnel have attended at least one ward round or case conference per week on their respective floors, and have held weekly or fortnightly meetings with ward personnel to discuss clinical problems which they select.

Staff psychiatrists and residents assigned to outpatient services have attended weekly, fortnightly or monthly case conferences, depending on the frequency with which the various units met. The Home-Care Unit, the Cancer Detection and Treatment Unit, the Physical Rehabilitation Unit, and the Team Clinic for Children were among the units receiving psychiatric consultation.

Community programs where nonpsychiatric physicians have been exposed regularly to psychiatric thinking include consultation to industry, prepaid medical insurance plans, and maternal and infant care programs.

Students

Because of the long-established major commitment of the Psychiatric Service of the Beth Israel Hospital to improving the understanding of the emotional aspects of physical illness, it is virtually impossible to define where the training of one group of trainees stops and another starts. As nursing personnel, nonpsychiatric residents, staff physicians and community physicians tend to influence one another mutually, programs geared toward groups other than nonpsychiatric physicians tend to strengthen the effect of this program under review, and vice versa. The number of physicians who are affected either directly or indirectly by this program are: 15 full-time and 4 part-time internists, 11 full-time surgeons, 2 full-time and 4 part-time pediatricians, 4 full-time and 4 part-time obstetrician-gynecologists, and 12 full-time anesthesiologists.

Program Evaluation

Constant informal discussion with, and periodic formal questioning of the trainees and staff of the project are undertaken in attempts to evaluate the effectiveness of the program.

Replication in other general hospitals is highly feasible, and depends on available personnel to instruct, and the goodwill between psychiatry and the other medical and surgical disciplines. Informal nonmedical mental health workers are less likely to succeed in hospitals with a traditional medical structure, unless they direct their attention toward the nonmedical personnel. In teaching hospitals, it is unlikely that the program can be replicated without adequate psychiatric staff.

The significance of the emotional aspects of physical illness has been so thoroughly integrated into the total approach of this hospital community over several years that it is not possible to define the impact of this particular program. The psychiatric dimension is discernible in all the deliberations of the hospital administration, psychiatric comment is frequently invited in widely divergent areas of hospital endeavor, and patients on the medical and surgical floors rarely decompensate to the point of requiring commitment to a mental hospital. Patient Support Services, in attempting to improve the interaction between housekeeping personnel and patients, sought consultation with the Psychiatric Service on how best to proceed with a training program. The Surgical Service has for 4 years included a psychiatrist on each of their teams which interview applicants for the surgical residencies.

The major strengths of the program are the availability of informal psychiatric consultation on the medical and surgical floors, and the emphasis on a psychiatric presence on the floors. Despite the very cordial relationships between psychiatrists and the other disciplines in the hospital, we have long since affirmed the notion that if psychiatrists are not visible on the floors, the emotional accompaniments of physical disease are less likely to be borne in mind. This latter factor is perhaps evidence of a major weakness of the project, namely its inability to modify the attitude of physicians effectively, once their styles have already been formulated in a medical school ambience of laboratory findings and physical symptoms. Fairly continuous reminders of the importance of psychological factors seem necessary.

Because there is a frequent chronological association between admission to hospital and the onset or origin of depressions, fears and phobias, and hypochondriacal symptoms, the population of a general hospital must be considered a population at risk. The importance of preventive psychiatry in this situation has been overlooked in recent years, especially in areas where major attention has been focused on community-based programs.

Psychiatry–GP–Postgraduate Education

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MH07135 1959–1973

Background

For the first 8 years of the continuing education programs, the efforts of University Hospital were directed exclusively toward working with nonpsychiatric physicians. During the past 2 years the project has had the opportunity to enroll first dentists and then nurses. The project anticipates continuing with these groups and broadening the base of participants as suitable opportunities arise.

Top priority in all groups is given to those allied health professionals involved at least part if not full-time in providing direct services to patients. The decision to impact first direct service providers comes from the whole orientation of the teaching method. The project depends on and actively involves participants in bringing their clinical experiences to the seminars. Recruiting methods are based on reaching out to hospital communities involved primarily in trying to improve the level of patient care.

Program Development

The program for physicians usually comes about by certain staff physicians contacting the project or by project staff approaching certain hospitals considered lacking in psychiatric input. Usually, initially, these seminars are discussed with the hospital administrator, chiefs of services and then presented to the staff physicians at a medical staff meeting. All interested physicians are then invited to an organizational meeting with an assigned leader. The leader is not only thoroughly screened by project staff but also approved of by members of the specific hospital staff. At the organizational meeting, participants and leader plan together a program tailored to meet the informational and attitudinal needs of the specific group.

The nursing groups essentially follow the same format. The groups meet together with the hospital's Director of Nurses to gain her approval for such a seminar. The psychiatric nurse leader is then asked to meet with the Director of Nurses. Out of this meeting usually has come a decision as to which nurses to invite to these seminars. Since the group size is sometimes limited (under 15) several different approaches to group membership are open. Options such as groups limited only to supervisors, to head nurses, to a specific unit (cardiac care) are all possible and available to the discretion of the leader, Director of Nurses and general hospital nursing staff. Again, there is an organizational meeting in which leader and participants plan together their format, content and meeting times.

To date, the dental contact has been limited to a group consisting of teaching and practicing dental sub-specialists from the Boston University Graduate Dental School. It is hoped that other groups will be formed there as new sub-specialists emerge from their various programs. These teachers of graduate dentistry are considered the best place to start in filtering psychologic information and attitudes to graduate school trainees and eventually to undergraduate dental trainees. The project also hopes to coordinate with the Dean of Continuing Education at the School of Graduate Dentistry in planning programs for the broader dental community as the school moves more and more into long-range preventative programs for economically disadvantaged children and adults.

Program Model and Content

Since the beginning of the program, small informal group seminars have been employed as the main teaching tool. From the initial groups, physicians were encouraged to bring in cases from their own practices as a springboard to discussion. Clinical relevance has always been stressed as a keynote to successful seminars. The project has always viewed these meetings as a professional activity and has kept the discussions limited to the physicians' practices.

As the project moved into a dental group and now into nursing groups, the same model has essentially been maintained. Since the project is interested in attitudinal change about all areas of mental health, it has been found that the small group seminar provides the most opportunity for attitudinal change through the informal exchange of ideas. Essentially, these seminars are offered bimonthly for approximately 1½ hours at a time mutually agreed on by the participants and the leader. The content and material covered have always been left to the discretion of the leader and his seminar group since each group has different needs and skills. There is no definite time limit to these groups. As long as the leader and the group feel mutually confident that their meetings continue to have purpose, the project supports continuation of the seminars over an indefinite period.

Recently, one of the physician participants asked a couple to come in for a consultation before his group. At the meeting, only the wife arrived. The group immediately felt helpless in dealing with the husband. The instructor combatted this by taking the whole group on a home visit to the husband. He responded very well to this group consultation in his home. The leader demonstrated for the group not only the couple's pathology but an important approach to reaching out to a very depressed man. This example is presented to stress the basics of the teaching program—flexibility, clinical relevance, and informal discussion.

The other cornerstone to the method has been the leaders' group. Essentially, all leaders meet at the group leader's home monthly for a 3 hour review. The focus of these meetings is the sharing of experiences and knowledge by the leaders to help them better understand and participate with their own group. These meetings have been used to review a special problem in a group, share the growth of a group and provide participants with new ideas and techniques. These meetings have proved invaluable especially for new leaders facing all the problems of starting such a group in a new hospital community.

The basic objectives have remained helping allied health professionals to mature and grow in their knowledge and security about emotional components of all forms of medical disease. The project has emphasized personality growth, psychosocial factors in illness, interviewing technique, and the use of psychotherapeutic techniques in the daily evaluation and treatment of medical patients.

Program Evaluation

Evaluation of the program has largely been in the area of attitudinal change. There has been observed a growth of appreciation in health professionals for the importance of their words to the patient and to the patient's family. Project staff members have noticed their willingness to spend that few extra minutes with the patient and explore with the patient psychosocial information. Staff members have particularly been pleased in impacting the place of allied health professionals in their communities. The groups have now moved to confronting emotional problems of the elderly in dynamic, economic and housing dimensions. Concern about gaps in health care now emerges such as problems for drug abusers, alcoholics and adolescents. All of these factors are hard to qualify but represent high quality impacts of the programs.

There are plans to introduce a self-rating scale called The Psychotherapy Preference Scale developed by Martin Jacobs, Ph.D., of this division. This 72-item questionnaire measures the relative importance which a person attributes to variables associated with psychotherapeutic practices such as dependability, sincerity, empathy, and warmth. This scale would be administered to both leaders and participants in the seminars to quantify attitudinal change over the life of the group.

Psychiatry–GP–Postgraduate Education

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MH08580 1964–1974

Background and Objectives

The current program is best understood by its historical development. The original and present objective is to develop skills in the primary physician that enable him to recognize, evaluate, and deal with pertinent psychological factors in his patients regardless of presenting complaint.

From 1964–1969, an attempt was made to fulfill that objective by 6 month-long weekly seminars. By the fall of 1969, it was apparent that primary physicians did not attend in adequate numbers.

Since attempting to "bring the primary physician to psychiatry" had failed, the new Program Director developed, implemented, and continues to develop programs which attempt to "bring psychiatry to the physician's everyday practice of medicine."

Methods and Content

A number of programs were offered to the some 1300 physicians at Cedars-Sinai Hospital in December 1969. Those that continue to expand are:

1. Psychiatrist and Psychologist Involvement in the Various Wards and Clinics, Rounds, Conferences, and Committees of the General Hospital: the weekly Chief of Medicine's Rounds is a model for these programs. Patients, selected entirely for medical reasons, are interviewed by a psychiatrist before he joins the rounds. The format affords opportunities to point up the high frequency of significant psychological problems regardless of presenting medical complaint, and the interplay between those problems and the medical complaint. The psychiatrist participates to the extent that he can make clear and significant contributions to the psychiatric education of the participants of the conference.

2. Interdisciplinary Research: Collaborative studies are in process in the followup care of patients who have suffered myocardial infarction, the psychological aspects of sterilization and failures in contraception. Discussions are currently underway on a complex study related to the influence of emotion on clotting and fibrinolytic mechanisms in patients with cancer, stroke, and heart disease.

3. Literature Review: Copies of articles dealing with significant psychiatric aspects of medical problems are sent to interested attending staff.

4. Special Programs: A wide variety of special programs are offered. However, experience with these programs corroborates past experience; that is, attendance is sparse whenever the physician is asked to "come to psychiatry."

Participants

By the end of 1971 the Program Director had accumulated enough experience to conclude that, though usually simply labeled as "resistance," the failure to "come to psychiatry" was complicated. For example, the physician usually does not have the time that adequate evaluation and treatment of psychological problems require. Simultaneously, he does have a clear responsibility to see to the appropriate evaluation and treatment of the patient's psychic status, as he has a similar responsibility relative to the patient's physical status. However, education to a responsibility without providing a realistic means of discharging that responsibility generates guilt and hostility toward, and avoidance of, the educative process. Clearly, simultaneously with, and even perhaps preceding the educative process, a practical means of discharging this responsibility must be provided.

During 1972, the Center has been investigating ways of assisting physicians in these time-consuming tasks. One possibility being explored is to integrate efforts with the clinical social workers, develop social worker-psychiatrist teams and ultimately utilize those teams to develop paraprofessionals. Five social worker-psychiatric resident teams are currently operating. Another avenue being explored is the utilization of registered nurses and licensed vocational nurses' aides. To date, efforts have been centered on training nursing personnel in the Cardiac Care Units, Intensive Care Units, and Hemodialysis Units. The training currently consists of five regularly scheduled groups of eight to ten members and accompanying in-service educational programs.

Future Trends

The past and present have been described. What of the future? This institution does, and probably will continue to, provide financial support for certain portions of the program which have become embedded to a significant extent in the fabric of the institution. For example: (1) the program has become an important aspect of psychiatric resident training and the contribution made by psychiatric residents will doubtless continue; (2) attending psychiatrists contribute their time; (3) the psychologist who is deeply involved in the nurse's training program is paid with other funds; and (4) nurses are given time off to get the inservice training described.

The Center is currently attempting to combine various programs so that a coordinated package of psychosocial services will be provided to the General Hospital. As the core of this package, the center hopes to have teams of psychiatrists, psychologists, social workers, nurses, paraprofessionals, and trainees in each of these disciplines. In addition to their service and educational functions, it is hoped these teams will provide greatly expanded research opportunities.

Further, the Center hopes to demonstrate to primary physicians that personnel we train make an invaluable contribution to patient care, and that ultimately the primary physician may wish to incorporate such an individual into his office practice. For example, a nurse so trained could train other personnel in the physician's office to take care of some of her other nursing tasks. She could maintain supervision of those personnel while she evaluated and, in certain instances, treated patients' psychological problems. She would be encouraged to continually upgrade her training via contact with the Community Mental Health Center. The nurse would thus become an in-office source of continuing education for the physician. If totally successful, that physician's office would in effect become a satellite to the Community Mental Health Center, collaborating in service, education, and research. Were such a program successful it might serve as a model for similar programs throughout the country.

Program Evaluation

Finally, there is the issue of program evaluation; i.e., how does the Center prove that the program should have a future? At this time, there is no solid data to prove that it should. The Center can provide no end of physician, nurse, and patient testimonials, and it would seem that those testimonials have to serve as the immediate justification for program existence. The Center is currently exploring two possible methods of documenting what is being done.

The General Hospital is gradually "problem orienting" its records. This system shows great promise as a method for documenting the effectiveness of service and educational programs. The other method has to do with dollars. Experience suggests that the program not only improves patient care, but may in some circumstances actually reduce the overall cost of medical care, if adequate mental health services are provided. There is some data in the literature supporting this experience, but it has not been followed up; the Center hopes to do so. If this could be documented, a number of financial, educational, and motivational problems might be resolved.

Psychiatry–GP–Postgraduate Education for Pediatricians in Child Psychiatry

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MH08379 1964–1974

Objectives

The goal of this seminar is to improve the diagnostic, therapeutic and preventive mental health services offered to children and parents by practicing pediatricians through a program of weekly 2-hour seminars and individual supervisory conferences. For the pediatricians attending, the objectives of this program in continuing education include increased comfort and skill in dealing with the emotional aspects of pediatric practice, and an increased sense of medical competence in areas for which they had not previously received training (e.g., diagnosis, treatment of reading problems). These changes express themselves in new behavior extending the limits of pediatric practice as evidenced by increased contact with schools via school conferences and increased use of interview skills in diagnostic and therapeutic work. Decisions about the time of the seminar and the content of the seminar are made in conjunction with the pediatricians attending.

Methods and Content

The 2-hour seminar, which has included a didactic component and a discussion period, has been the mainstay of this program. Related to this have been observed interviews by child psychiatrists and pediatricians, and audiotaped interviews by pediatricians in their offices. These approaches, and the case discussions stemming from the work of the pediatricians, have been related to the content areas selected with the pediatricians.

In general, the content focused on those areas where psychiatric understanding enhanced the effectiveness of the pediatrician. These included sessions on personality development, taking into account normal and pathological patterns, and on psychological aspects of physical disease—reactions to various acute and chronic illnesses, surgical procedures, physical handicaps, and to programs of treatment and prevention.

Specific content areas are diagnostic process of child psychiatry and its application to pediatric practice including techniques of interviewing children and parents, family, social and environmental factors, parent-child relationships; the child psychiatric diagnostic examination; psychological studies—types, indications, values and limitations; comprehensive diagnostic formulation of clinical, dynamic and genetic diagnosis and treatment.

Treatment methods as a content area include environmental approaches through home and school and treatment of parents. The nature of the patient-physician relationship is stressed with special reference to the practice of pediatrics; child psychotherapy—level and goals, techniques, basic principals, methods for the pediatricians and physicians; indications for specialized psychiatric interventions, special schools, and various inpatient settings.

The specific function of the pediatrician is included as content when he plays a role in specific situations—divorce, adoptions, the one-parent family, accidents, deafness, birth of sibling, etc. Techniques of directly handling unusual or common problems with children and parents around times of deaths, births, sexual development, discipline, dating, school problems, drugs and social behavior, etc. are included. The management of referrals and preparation of children and parents for special physical, psychological and psychiatric examinations are stressed.

Interprofessional relationships, special features of the pediatrician in relation to social workers, clinical and school psychologists, psychiatric, pediatric and public health nurses, teachers, and other school personnel, social and health agencies and institutions are included. Here the role of the pediatricians in fostering mental health and preventing mental illness is emphasized.

Students

The students of this program are pediatricians in practice in this community. Approximately 120 members of the Cincinnati Pediatric Society and 28 pediatricians have participated in this program, some throughout the 8 years of the program. Six Fellows in child psychiatry have participated in the program to learn about this method of teaching pediatricians.

Program Evaluation

The program is evaluated in two ways. Periodic individual contacts are made with members of the seminar to review the fit between their educational needs and the program offered. In at least three sessions during the year, the group considers what its experience has been and what its input to future planning might be. The potential exists for replication of this program at all levels, as this seminar is a modified Balint group offering an intensive experience to pediatricians. The training design has remained essentially unchanged over the years the program has existed.

By providing a training opportunity of an intensive ongoing nature for pediatricians, it has been possible to enable pediatricians to include mental health services as part of their function. Through this seminar, pediatricians are able to view these services as a natural extension of their interest in health, a preventive approach, and continuity of care. For some pediatricians it has provided an avenue to gratification in practice where their conventional pediatric practice was providing fewer gratifications and increasing frustrations.

Psychiatric Postgraduate Education

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MH08269 1963–1974

Objectives

The general educational objective of this program is to provide basic fundamentals of the doctor-patient relationship so that physicians and their staff may facilitate the potential for increasing the patient diagnostic assessment and treatment for referral. Specifically, the program tries to help the physicians and their staff better understand the meaning of the illness to the patient and how this relates to the patient care, family role disturbances or community resources, and to ensure that the physician has some idea of a diagnostic impression of the patient and know something about the communication from patients which are connected with other aspects of their reaction to illness. Also included are the specifics in terms of basic use of drugs in psychiatry, referral methods and some proficiency in basic supportive therapeutic techniques. Attitudinal change or behavioral change has been aimed toward helping the physicians establish a more understanding and accepting attitude toward the many important areas which otherwise they might ignore. They find that certain behavior patterns on the part of patients make them defensive, make them feel helpless or increase their feeling of not knowing how to manage certain patients.

The target groups for trainees include basically nonpsychiatrist physicians and their staff, whether social workers, nurses or other paramedical personnel, who are working with the physicians in terms of patient care. Recently, target groups have been included which work with certain mental health centers. The objective in that case is to increase not only the physician's skills but his knowledge of mental health services available in his community.

Methods and Content

Training methods used in the program include a series of 8-week courses designed to provide basic skills and those which are designed to improve the physician's use of himself and his assistants in caring for the mental health needs with which he is confronted. The specific content areas include (1) the essentials of the doctor-patient relationship and its meaning; (2) a simplified method of understanding basic personality reactions and the counterreactions which they engender within the physicians and others; (3) an understanding of the cathartic or abreactive ways or other ways of supportive therapy aimed for increasing and developing within the physician skills for coping with problems ranging from the aged population, grief, depressions, marital problems, family counseling, drug abuse and alcoholisms. Other training methods are the use of actual patient interviewing, the use of videotapes and vignettes of film showing doctor-patient interactions with discussions after some preparation of didactic material.

Some courses consist of a meeting with several physicians once a week over an 8-week period of time. Others consist of the presentation of didactic material and discussion with patients around discussion with physicians that may occur during a morning or an afternoon workshop on some particular activity. Some of these workshops within the recent year and others have included presentations to clergy, social work students, and directors of nursing, teachers of nursing in chronic care hospitals and nursing home attendants.

Students

The trainees represented are mostly M.D. physicians or doctors of osteopathy, and there are large numbers of nursing students, social workers, and nursing home attendants who have come to be included more and more within the whole program. There is a wide variety of the nature of the prior training and a breakdown of prior training had been submitted in 1969 as part of a research project describing the prior training of the physicians, M.D. physicians group. Significant non-M.D. personnel have been included in the past few years. A breakdown of this entire population will be reflected in the fact that within the last year, some 1,095 trainees have been seen as a result of both the long-term and short-term courses. There are over 2,000 physicians in the State of Colorado who might be potential trainees. Statistics on the breakdown of these potential trainees are included in a questionnaire on the Colorado nonpsychiatrist physicians which was submitted at the beginning of the second 5-year period of this project.

Program Evaluation

The program evaluation is focused mostly on those who are in small group intensive courses. This consists of a questionnaire which in brief asks the physicians why they took the course, what they found they had learned from it, and how they might suggest the course be more helpful in the future. This is one of the inputs for program planning. For example, after going over many of the program evaluations in which suggestions for future planning and/or particular instructor's methods were assessed, it was found that there might be physicians interested in courses which focused on the emotional aspects of the impact of the practice on the physician and his family. It is not felt that this type of course which was successful would have been acceptable some 5 to 10 years ago. However, it will be repeated because of the amount of customer satisfaction it engendered. Future plans are mostly laid out with meetings of the faculty and discussion with the program director. There are many inputs of the program director's meetings; the Physician Education Project of the American Psychiatric Association provides many sources of creative and varying approaches to treatment. The program has also used consultants from such places as the National Training Laboratories to help in the modification of methods and content within the groups.

The potential for replication of the program at local, regional or national levels depends upon the determination of the needs on the part of the physician with an understanding of how they might best be met and that some types of programs which may be suitable for certain areas would not be acceptable at all or would not be accepted for outlying districts or other areas. Assessment of impact ranges from finding out that all the suicide attempts were going to be managed in a different way within a community hospital to feedback from nursing personnel concerning the change in attitudes of physicians toward the parents of small children who are in the hospital, with more direct communication with the physicians. There also has been an impact in terms of the place that the program falls into in the statewide interest in continuing education in terms of comparison of programs, program areas and others who are doing similar types of work. This is done through the Denver Metro Consortium on Mental Health representing various other State, hospital and community mental health centers and directors of some education programs within the hospitals.

The changes which have occurred in the program have been to include more, briefer courses reaching out to larger groups of physicians and in response to other groups which do not primarily include physicians within them such as nursing personnel and those in charge of chronic care, including supervisors. It has been found that the paramedical personnel within the offices of physicians often carry the brunt of the support and understanding of patients, and they have been successfully integrated into many of the teaching methods and programs without difficulty. Indeed, such groups often are more interested and have more available time and have less skepticism about the ability to help in this area with patients.

One of the weaknesses of the project is recruitment. Many of the physicians who need it most have not recognized their own needs. They often will state that they want such programs but they resist the more dynamic or involved groups. However, the faculty has always been able to engender enough interest in those who are interested in coming to the shorter but more intensive programs, such that when they finish the programs there is some resistance to finishing the group and they wish to continue. Particular figures are not available at this time on those who repeat courses, but it is not out of line with those seen in other programs.

Psychiatry–GP–Postgraduate Education

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MH10753 1967–1974

Background and Format

At Confederate Memorial Medical Center, a 1,000-bed teaching hospital with approved residency in psychiatry and all other medical and surgical specialties, the Department of Psychiatry sponsors a postgraduate education program in psychiatry for general practitioners and other nonpsychiatric physicians, entitled "G-P Study Group in Psychiatry." This study group is now in its twelfth year of operation and in the sixth year of funding by the National Institute of Mental Health. It is recognized and accredited by the Louisiana and American Academies of General Practice. The general practitioners who participate receive 4 hours of credit per session from the LAGP and AAGP. The group meets at least three, usually four, times each month. The meetings are held on the psychiatry service at Confederate each Thursday night and last up to 4 hours.

There are currently 26 enrollees in the group, many of whom have been active members since its inception. The course of instruction is deliberately designed as an open-end program in order that these dedicated physicians may continue year after year, to participate. The teaching sessions are conducted on a year-round basis, with a short break during the summer.

The format is simple, yet comprehensive and intensive. The enrollees receive both didactic and clinical instruction and supervision in psychiatry. Two meetings per month are devoted to didactic presentation by guest speakers. The other two consist of presentation of psychiatric patients who are being treated on the psychiatry service of the hospital. Patients are interviewed by enrollees; interviews are critiqued; mental status is reviewed; physical and neurological examinations are discussed; all laboratory data presented; psycho-social history and psychological test findings are reviewed. The case is then discussed, and appropriate treatment and referral decided upon.

Objectives

Generally, the objective of the program is to familiarize the enrollee with the psychiatric conditions with which he must deal in his day-to-day practice. More specifically, each enrollee is instructed and supervised in proper interview technique, accurate diagnosing, and specific therapeutic modalities to be utilized. Toward this end a number of the enrollee-physicians utilize on-the-job training in the setting of a community mental health center and regularly devote a certain number of hours each week to this activity.

Students

Over the years, as space requirements have permitted, additional disciplines have been taken into the group. From the beginning, there were three dentists participating in the group. During the past three or four years, a limited number of selected ministers have become participants with a goal of improved pastoral counseling. Psychiatric social workers, clinical psychologists and registered nurses are now included in the group. With this multidisciplinary makeup of the enrollees the current functioning of the course has added interest and has taken on new boundaries for learning and discussion.

Major decisions concerning program content are arrived at through concensus by the enrollees with final approval by the program director. When a particular subject is requested for discussion at some future date the content is considered and all efforts are made to obtain a speaker who is most versed in that particular area. To date the Center has utilized the talents of all of its local psychiatrists, psychologists and other mental health professionals. In addition there have been guest speakers from other cities in the State, and from other States including Texas, Arkansas, Tennessee, Mississippi, Colorado, Arizona, California, Illinois and New York; and from other countries, including Turkey and Canada.

Evaluation

Program evaluation is an ongoing process, carried out concurrently by the program director, the local faculty and by the enrollees themselves. This is accomplished through discussion and frank critique of speakers and their presentations, and by an occasional written examination and questionnaire. Although the overall program is considered to be unique, it is not beyond duplication in other areas where a genuine desire for learning is present.

Except for the addition of other disciplines there has been no substantial change in the program over the years. The format remains very much the same, yet with the various disciplines now represented, the content is improved due to ever increasing points of view and interest.

Because of the various features described, this approach is an innovative one in the field of continuing education in the mental health field. This is evidenced by the increasing interest shown by the participants, both old and new, and the impact it has had within the community. The pattern adopted for this program, originally for general practitioners only, could easily be utilized in any area of specialization as a model for a continuing education program which is now advocated for all physicians.

Psychiatry–GP–Postgraduate Education

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MH07923 1962–1973

Objectives

The major overall objective of the Florida Program is to provide forums for collaborative learning and the updating of information for a wide variety of students so that there will be maximum utilization of all mental health manpower resources in the State.

The specific objectives for a particular course are individually designed. The goal setting process for each of the educational programs takes into consideration information obtained from a survey sent to each community mental health center requesting a listing of priorities of educational needs. In addition, specific course goals are worked out via meetings and planning sessions between a faculty coordinator and local groups to match objectives, content, and teaching techniques of each course to the needs of the particular locality.

Methods and Contents

The training methods involve lectures, seminars, small group sessions, and workshops. A wide variety of teaching aids are utilized, including films, audio-visual aids, closed circuit television and patient participation. The specific content for each course is individualized according to the objectives of the course in the specific locality. However, information obtained from a written survey has delineated the ten most popular areas of content as follows: alcohol/drug dependency; behavior modification; group therapy; family therapy; emergency and crisis intervention; community consultation; primary prevention; psychopharmacology; new methods of delivery of services; and mental health administration.

The time sequence for each course consists of 8–16 hours per course. The time sequence consists of an initial meeting of all faculty and students for approximately 1½ hours, followed by a number of workshops, seminars or discussion groups which last 2 to 3 hours, and concluded at the end of the course by a summary meeting involving the entire group. Following the initial 8–16 hour presentation, the small groups continue to meet under the supervision of local faculty for 2 hours each week for a total of 10 weeks.

Students

High priority is given to mental health professionals, physicians, and allied mental health workers. Decisions about the type of students are individualized and, in addition to the above, include all the mental health disciplines, clergy, peace officers, mental health technicians, indigenous personnel, and mental health district board members. The number of students in each category varies with each course, and there is no fixed pattern. The majority of the students who have participated in the past courses have been physicians. The program has only recently broadened in scope to include this more diverse group. The amount and nature of prior training of the students are not uniform. This varies from locality to locality; ranging from the well-staffed facilities and well-trained personnel in the large metropolitan areas to less well-trained personnel and staffed facilities in the rural areas.

Program Evaluation

The individual courses are to be evaluated in conjunction with the State Bureau of Planning and Research. The primary method of evaluation will be questionnaires to critique the faculty, content, and methods of instruction used. The critique will provide for constructive suggestions by the participants on the impact of the course on himself and others, as well as its effect in improving health services.

The primary design of the Florida Program, which includes a mobile didactic faculty conducting courses in local communities throughout the State and using local faculty for the continuing 10-week followup work, has potential for replication at regional and national levels.

Recent Statewide changes in mental health programs initiated by the State Legislature have coincided with the development and modification of the Florida Program. These changes have compelled the program to expand its educational activities so they become integral aspects of the mental health delivery systems. These changes include: the division of the State into 23 mental health districts under the direction of a Citizens' Board, the deletion of the State's former commitment procedures, restoration of civil rights to formerly committed patients, a new stress on voluntary admission to the State hospital system, the creation of local receiving facilities, and the decentralization of the Division of Mental Health into four major geographic areas. The current emphasis is to develop alternate treatment facilities at the local level and avoid hospitalization. The Florida Continuing Education Program works with the professionals, paraprofessionals and consumers at the local level to ensure maximum utilization of the local manpower force.

In anticipation of these changes, the Florida Program has broadened its scope to include trainees, other than physicians, who are involved in the health delivery systems. The basic design of the program has remained the same. In some instances, again based on local needs, the course design may be modified.

The Florida Program has been developed to involve the University of Florida with the continuing education of a variety of professional and paraprofessional personnel responsible for health delivery in the State. The program design is such that the courses are carried to the local community which provides local input into content as well as curriculum design. The major weakness in the program is the difficulty of developing course design and content with a heterogenious student population. At the same time, this weakness affords the challenge that concerns all continuing education programs—the development of a core curriculum that is important regardless of the individual's background, training or area of work in the mental health field.

Psychiatry–GP–Postgraduate Education

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MH11371 1968–1973

Objectives

Many patients seen in physicians' offices, including many with physical complaints, are suffering from emotional disorders. These disorders range from mild situational reactions to chronic, severe neuroses and psychoses. The seminars are designed to assist physicians in understanding these patients, developing skills to evaluate and treat them, and utilizing appropriate consultation and referral resources.

Achievement of these goals will result in the physicians' greater acceptance of emotionally disturbed patients, increased scope of their practices, and improved effectiveness in managing patients with emotional problems.

Methods and Content

A three-stage program was initiated in 1968. The first stage, consisting of an annual 1-day symposium, was expected to attract large numbers of physicians. Its objectives would be to impart specific information about new developments in psychiatry and to stimulate the physicians' interest in learning more. This interest would be met by the second stage, a series of small-group discussions that would add to the physicians' knowledge and skill in the diagnosis and management of emotional problems in their patients. It was also expected that these seminars would affect the participants' attitudes in dealing with patients with emotional problems. The third stage would consist of individually tailored programs for the relatively few practitioners who wish to learn more sophisticated psychiatric concepts and techniques. The concept of a three-stage program has undergone modification based on experience with the program. The hope of using 1-day symposia as a means of engaging the interest of physicians in the seminars was not fulfilled. Three have been held, and each was successful from the standpoint of attendance. As far as can be determined, however, not one physician has registered for the seminars as a result of interest developed by the symposia.

The concept of "long-term courses has also been modified." The seminars have, in effect, become long-term, and each group follows its own interests. The case-oriented discussion remains the principal focus. Course content has undergone evolutionary change. Initially, the seminars had a structured format of literature presentations, case discussions, and patient interviews, with subjects to be covered scheduled before the course began. As participants expressed their own preferences, greater flexibility was allowed, and each group tended to develop its own style and dealt with very different issues.

Experience has led to using a uniform method, while at the same time, employing greater diversity of content. The format is the case conference, held once weekly for 1½ hours, for 12 weeks each fall and 12 weeks each spring.

Students

The "target" population is the 4,000 practicing physicians in the Washington, D.C. area. All who have expressed an interest have been admitted to the program. The program is interested in reaching primary physicians, those to whom patients will make their initial appeal for help.

The focus of effort has shifted from promoting the program generally to directing attention to members of hospital staffs. Seminars have been offered at three community hospitals, in addition to those held at Georgetown University Hospital.

Each new seminar series is planned jointly by the Project Director and a participating nonpsychiatrist physician who is familiar with the needs of the physicians on his hospital staff. Continuing seminar groups plan their own curricula. The result is an improved process for directing each seminar to the precise needs of the participants.

Sixty-six physicians have taken part in the seminars as of June 1972, and 480 have attended symposia. Physicians in several fields of practice have taken part in the seminars. The numbers, by specialty, are: Pediatrics-18, OB-GYN-17, General Practice-13, Internal Medicine-13, Surgery-2, Physical Medicine & Rehabilitation-1, Neurology-1, Occupational Medicine-1.

Program Evaluation

Results of the teaching effort have been assessed from two standpoints—change in attitude and change in style or scope of practice. The tools of measurement were rough: observations by faculty during the seminars, queries of the participants at the completion of each series, and a questionnaire sent in April, 1971, to all who had taken part in the seminars during the program's existence.

Forty-eight physicians had participated in at least one series of seminars when the questionnaire was sent—15 obstetrician-gynecologists, 13 general practitioners, 11 internists, 4 pediatricians, and 5 others.

Eighteen physicians did not return for additional series. Based on their own comments and staff observations, there was little or no change in their attitudes during the course of the seminars. The questionnaire revealed that the seminars may have contributed to later attitude changes. Of the 11 respondents who quit after one semester, two of the three who were in this year's group reported no change. Of the other eight, who had participated 2 to 4 years previously, seven reported improvement. Eight of the 11 thought that they had added to their knowledge or skill in the care of patients.

Thirty physicians participated in two or more series. Their attitudes appear to have changed in direct proportion to the length of time in the program. Nearly all experienced a feeling of greater confidence or comfort in dealing with patients. Some expressed greater change by such statements as that they were able to manage troublesome patients and were better listeners and less judgmental and more supportive with their patients.

An attempt was made to assess change in the practitioners' style and scope of practice. Of the 26 with two or more semesters who responded to the questionnaire, all but one reported increased knowledge or skill or both which had favorably affected their practices. Comparing their questionnaire responses with the increased knowledge they displayed in the seminars, it was inferred that their self-assessment may be too modest; they probably handle patients better than they realize.

Of the eight practitioners who have completed at least 3 years of seminars, all report change in the scope or style of their practices in the direction of greater sensitivity and attention to the emotional aspects of medical problems; the younger physicians generally effect the greater changes.

Psychiatry–GP–Postgraduate Education

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MH11015 1967–1974

Objectives

The general objective of the training program is to help the nonpsychiatric physician improve his knowledge and management of psychiatric problems. Specifically, the program intends to provide a conceptual model of personality functioning, particularly as it operates in the production of somatic neuroses and psychological reactions to organic illness and in the doctor-patient relationship.

Methods and Content

Training methods include the following:

1. Lectures. Formal lectures are still widely used, particularly in organized courses.
2. Lecture-demonstrations. Extensive use is made of audio-visual material to illustrate clinical problems and processes. The department has well equipped TV studios and an extensive library of taped clinical material. Properly edited and selected, this material has been found to be one of the most efficient and effective ways of teaching. With portable play-back equipment, this technique is used in off-campus courses and presentations as well as on campus.
3. Informal seminars. These are scheduled at weekly or monthly intervals for a specified number of sessions. The seminars consist of informal discussions, semiformal lecture-demonstrations, or discussion of the participants' case material, depending on the composition and needs of a particular group.
4. Consultation. A faculty member is assigned more or less full time as an intake physician. His duty is to take care of the

referral and intake process but also to provide an educational opportunity for the referring physician or agency. This service provides suggestions and advice as to how to help the patient be referred and how to help the patient without referral. When patients are accepted, continued involvement of the referral source is attempted for educational as well as therapeutic reasons.

5. Clinical visitation. This involves participation in routine activities of the department such as attending ward rounds, clinical conferences and various teaching seminars.

Specific content is determined by the type of student. Most of the program's organized effort has been directed at nonpsychiatric physicians, with a consequent focus on psychiatric problems in general practice. The primary content focus has been on helping the physician understand and deal with psychological problems that are expressed in somatic symptoms. Other topics that are frequently included are marital and sexual problems, alcohol and drug abuse, psychopharmacology, and emotional problems in childhood and adolescence.

On-campus presentations include concentrated 2-day psychiatry courses, half-day programs in general practice courses, lecture and panel participation in other speciality courses in which the program's faculty parphasis is being placed on presenting psychiatric programs at regularly scheduled medical society and community hospital staff meetings. This has been found to be one of the best ways to reach a broader spectrum of nonpsychiatric physicians.

Students

The number of physicians who attend the 2-day on-campus psychiatry courses range from 35–60. Some of the other on-campus courses, and seminar series. Increasing emticipate have much higher attendance rates. The highest enrollment rates are in courses of interest to ministers. Enrollment in informal seminar courses is limited to 12. Attendance at off-campus presentations is determined by the size of the community.

Program Evaluation

The Department of Continuing Education routinely asks the participants in all on-campus courses to fill out an evaluation questionnaire. However, this is a measure only of what the participants like or dislike and what they subjectively feel is helpful to them. While this provides valuable information for future planning, it does not measure the effects of the program on the participants' practice. The program gets some encouraging feedback on this, but not in a comprehensive or organized fashion.

One of the most well received types of presentation is the use of video-taped illustrative clinical material. With some further editing and organization, much of this material might be replicated and be used on a wider scale in other teaching programs. The program is currently in the process of programming some of this material for the use of its undergraduate students. If this is successful, it plans to make the material available to practicing physicians for individual use. With the advent of inexpensive TV playback equipment, programmed material on TV cassettes could become a major approach in continuing education.

One of the major problems in continuing education programs for physicians is the difficulty in reaching a wide audience. Only a small percentage of physicians have a feeling of personal responsibility for mental health.

Psychiatry–GP–Postgraduate Education

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MH12593 1971–1974

Objectives

The overall objectives of this continuing education program are the following: (1) to make such programs available to other physicians throughout the State; (2) to get physicians to recognize incipient emotional reactions and undertake preventative measures; (3) to have physicians recognize milder emotional problems and the increased number of possible responses and solutions; (4) to increase the physicians' familiarity with the skills of the psychiatrists and other mental health professionals and their freedom to refer the emotional problems which they cannot handle; and (5) to increase the psychiatrists' and other mental health professionals' familiarity with the general physician and their freedom to refer back emotional problems which the general physician can treat. (If the psychiatrist deems that he can refer back an emotional problem to a general physician and the physician is adequately prepared to handle it, then the program would be a success.)

Methods and Content

To achieve the goal of helping the primary physician assume his appropriate role in the case of emotional problems of patients who are in his community, the seminar method has been augmented. This method, which provides for 10–15 physicians meeting with a psychiatrist once a week for 2 hours and continuing for 30 seminars or sessions, has proved to be the best method of accomplishing this goal.

The format of the course is centered about case presentations and problems from the physicians' own practices. Didactic aspects of the problems were discussed as individual cases brought them up. Needless to say, due to the feedback of the individual physicians involved, the participants learned not only about their patients but also about their emotional problems within their own practices.

Students

The students are all the physicians (which includes all the specialities) in the State who are interested in advancing their knowledge in emotional problems. It is hoped that other professionals including nurses, technicians, hospital personnel, and mental health coordinators and professionals will attend some of the sessions and become motivated to learn more about psychiatric problems.

Evaluation

A questionnaire sent out to all the participants throughout the State provided data to evaluate the course. There was a 62 percent response to the questionnaire. Ninety percent of the participants thought that the course format of weekly 2-hour sessions should remain the same. Twenty-seven percent would like to have more patient presentation and 47 percent expressed views of having a somewhat more didactic overall presentation. Interestingly, over 90 percent of the participants thought the course was excellent. The participants also expressed desire to continue the course and 97 percent stated that they would recommend other doctors to enroll in the course.

Evaluation has also been accomplished through visits by the State psychiatric advisor and program director of the various courses throughout the State. Constructive criticism and changes have been beneficial.

A 2-day grant seminar also has been conducted with the psychiatric teachers, GP coordinators, program director and psychiatric advisor, discussing and evaluating various aspects of the overall program.

The strengths of this program have been many. The students who have been involved in the program have stated that they have learned more psychiatry than in any other program they have undertaken. They have learned not only how to handle many psychiatric problems in their offices, but also have gained some insight into their own problems and shortcomings.

The success or failure of the program depends on the competency of the psychiatric teacher. His views, methods, control or lack of control of the group or students (whichever is appropriate at the time) determines how successful the course will be.

The overall purpose of this project is to help the primary physician assume his appropriate place in the care of the emotional problems of the patients in his particular community. The intent is to make as many general physicians as possible more sensitive to, and understanding of, emotional problems of their patients; improve their ability to detect early psychiatric problems of their patients and aid them in the overall management of same. This has been and will continue to be accomplished.

One of the weaknesses of the program has been that it has been too didactic at times. The program is strongest when a mixture of didacticism and discussion are in the proper perspective. Another weakness emerges when too many patient interviews are introduced. When this happens, the course can be reduced to a banal voyeuristic game.

Continuing Education–Psychiatry

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MH11396 1969–1973

Objectives

The general aim of the program is to acquaint the physician in practice (family practitioner or nonpsychiatric specialist) with the fundamental principles of psychiatry and how they can best be applied in the day-to-day practice of medicine. The specific aim is to improve the physician's knowledge and skills in handling the doctor-patient relationship, history taking, interviewing, diagnostic techniques, treatment methods applicable to the office or clinic, and utilization of community resources.

Methods and Content

Lectures, question-discussion periods, small group teaching sessions, and case presentations are the major methods of teaching content. Faculty members, utilizing these methods, teach in areas in which they are expert. The specific content of each time sequence is determined after consultation with the faculty and the trainees. When required by content, the program teaching faculty is enlarged to include appropriate persons from other disciplines and from the community. The content is focused on those areas of psychiatric knowledge most likely to improve skills that can be applied in general medical practice: the doctor-patient relationship, interviewing, history taking, diagnostic method, psychological treatment methods such as brief psychotherapy, supportive techniques and counselling, psychopharmacology, new methods of specific therapy, referral, and use of the psychiatrist as a consultant. These considerations shape the specific content, varying from year to year, on such subjects as community psychiatry, child-adolescent psychiatry, sex education and problems, drug abuse, and geriatrics, for example. The time sequence consists of about 20 hours for each course, over a 3-day period. Each course includes approximately 8 to 10 hours of lectures, 4 to 6 hours of case presentations, and 3 to 4 hours of small group teaching.

Students

The students are practicing physicians in Iowa and the northwest quarter of Illinois. All have an M.D. or D.O. degree. The population of potential trainees numbers between 3,000 and 3,500. At least half are family practitioners. A small but growing proportion are foreign medical graduates. Their psychiatric undergraduate training, graduate experience, and orientation are varied. Many of the trainees, particularly those who graduated more than 25 years ago, describe their undergraduate psychiatric training as inadequate.

In the April, 1972, training program, 20 of the 30 trainees enrolled were family practitioners from Iowa, Illinois, and Indiana. Ten were specialists, including three who limit their practice to psychiatry.

Program Evaluation

Evaluation of the program content for new knowledge and skills applicable to clinical practice is made by the trainees. They are asked to rate all the content for its value to them in practice. Evaluation of teaching methods and performance is done by the course director and other faculty members.

The program could be replicated, if there were a demand for it. In fact, a portion of the 1972 spring program made up a considerable part of the 1972 Scientific Meeting of the Iowa Psychiatric Society, and it is anticipated that this will happen with the 1973 program.

This Continuing Education Program reconfirms that the average practitioner has a considerable desire not only to maintain but improve his skills and knowledge. The affirmative response by the trainees, according to their evaluation of the program, has served to increase the program's determination to continue work in their behalf.

The strength of the program is the content focus on improving knowledge and skills which have value to the practitioner in the daily practice of medicine. The content evaluation by the trainees will quickly balance any errors in judgment made by the program director and the faculty. A major weakness is the training and experiential heterogeneity of the trainee group. But this is a problem in all Continuing Education efforts.

Psychiatry–GP–Postgraduate Education

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MH11083 1967–1974

Background and Objectives

The training program is designed to obtain the interest of nonpsychiatric physicians to understand early emotional problems and disorders and to help them deal more effectively with the emotional aspects of illness generally. It is felt that by gaining a better understanding of the psychological make-up of patients they see, they will be better able to administer treatment to those patients requiring psychiatric care and to recognize the disorders that require referral to and treatment by a psychiatrist.

Methods, Content and Participants

During the first year of this program, July 1967 through July 1968, a series of eight seminars was held at 2-week intervals from September to December, using the facilities of the Northampton VA Hospital. It was hoped that a different group of physicians would want to attend the series in succeeding years so that in 7 years enough physicians would have been exposed to this education program to become interested in the psychiatric problems of everyday practice and to help them play a more effective role in the treatment and prevention of mental illness. However, the physicians did not show too much interest in this type of program and the schedule was changed so that three to four workshops, seminars or lectures have been held annually. These educational activities are planned around psychiatric subjects of interest to the general practitioner and other professionals in the area who are involved in the treatment of mental illness. The speakers or groups who are invited to conduct the programs are well known and expert in the field to be discussed. The themes have dealt with the recognition, dynamics and treatment of emotional disturbances. The programs are usually planned to be either of a 1- or 2-day duration, with 7 to 14 hours of training activity.

Attendance at these programs has ranged from 100 to 270 persons. By extending invitations to both the medical and paramedical community, including psychologists, social workers, nurses, etc., it has been found that there is more likelihood of having a large number of general practitioners and psychiatrists attending. Also, this enhances the interaction with the speakers and allows deeper exploration of the subject matter. The good response of psychologists, social workers, nurses, counsellors and educators has allowed these meaningful topics to be widely disseminated.

Programs for this year are now being arranged around such themes as recognition and management of the schizophrenic patient, problems and management of the aged, and alcoholism. All areas of possible interest will be explored and as speakers and/or group leaders become available, plans will be developed. Due to the success of programs in the past, the same format will be followed to include formal lectures followed by question and answer periods, seminars using several speakers and panel discussions, and workshops involving active participation by those attending and group interaction with the guest speakers and panelists.

Psychiatry–GP–Postgraduate Education

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MH07194 1960–1974

Background and Objectives

The Brooklyn program for the psychiatric indoctrination of the nonpsychiatric physician has been sponsored jointly by the Medical Society of the County of Kings, the Brooklyn Psychiatric Society, and the Brooklyn Chapter of the American Academy of Family Practice. They are now concluding the 15th year of this program. It has been characterized by a gradual and constant expansion and continued enthusiasm by the participating physicians and instructing psychiatrists. It arose out of dissatisfaction with a formal didactic program that had formerly been in operation.

It is estimated that roughly 50 percent of all visits to the general practitioner may be due to symptoms precipitated by emotional stress. The psychiatrists of Brooklyn came to the conclusion that the general practitioner should be utilized as the first line of defense against mental illness in their geographic area, a population of over 3 million people.

The Program

The need has been emphasized to educate the general practitioner to the presence of emotional problems encountered in daily work with his patients. The program has stressed the doctor-patient relationship and the need for the doctor to see the patient as a human being in distress rather than as a conveyor of an organic syndrome. By limiting the groups of physicians to six or less, when assigned to a psychiatrist the more diffident practitioner entered into active discussion. Group therapy and the development of the transference phenomenon have been avoided by limiting the number of sessions to six evening sessions twice a year. The seminars are scheduled for 2 hours but actually run 3 to 4 hours. They are held in private offices of each designated psychiatrist and are conducted informally. It has been the policy to assign physicians who attended previous seminars to a different psychiatrist at each subsequent enrollment.

The efficacy of the teaching program was proved by the results of an official questionnaire. Most of the physicians responded that they did feel more competent and comfortable in handling the usual emotional problems of their patients and that they issued fewer prescriptions for the use of sedatives. Since 1958, 910 general practitioners of Brooklyn have participated in one or more of the educational seminars.

The program received little response from the younger physician. Eighty-five percent of the doctors who applied were past the age of 43. Far less attention had been given to clinical psychiatry at medical schools prior to 1946. The physician who had been in practice for 20 or more years had finally learned through trial and error that emotional factors play a very important part in clinical medicine.

The general practitioner is considered a rugged individualist who prefers to be a collaborator in his quest for postgraduate education. Material obtained from didactic lectures can be obtained easily from medical texts and various journals. Busy, overworked clinicians seek direct answers to the problems encountered in their daily practice. The informal round table seminar seemed the best means of allowing interested men to question the instructor and gain specific information.

Each applicant was allowed to check three topics in order of preference. The topics chosen were the result of conferences between the three participating organizations, and as time went on requests for other topics were received and added. The following seminars were offered:

1. Psychosexual problems in general practice;
2. General psychiatric problems of private practice;
3. Emotional problems of skin disorders;
4. Emotional factors in the doctor-patient relationship;
5. Psychosomatic problems (asthma, colitis, ulcers, etc.);
6. Emotional problems of the aged;
7. Emotional problems of children;
8. Emotional problems of adolescence;
9. Emotional problems of drug abuse;

10. The problem of alcoholism in general practice.

The psychiatric staff was composed of men possessing a wide range of training but who basically showed an interest in community welfare. Within the group were members of practically all the known psychoanalytic schools and psychiatrists who utilized a more eclectic approach in therapy. The enthusiasm of the instructors fostered a favorable "esprit de corps," and their theoretical differences were minimized by their common effort to disperse psychiatric knowledge.

It is quite obvious that patients suffering from emotional problems will develop various somatic complaints which would require them to visit their family physician. The latter, when oriented to the possible psychogenic factors hidden behind the somatic complaints, will be in a better position to understand his patient. The practice of mental health and the alleviation of acute anxiety states can thus be handled by the family physician, without referral to the psychiatrist. The warm, oriented, understanding doctor could be considered a therapeutic agent for an emotional catharsis. This tendency may free the psychiatrist to concentrate his time and effort on the patients who have more serious personality disturbances.

The staff has been impressed with the ability that many general practitioners display intuitively when facing the emotional problems of their patients. The physicians do give advice and play an active role but frequently have no awareness of the dynamics involved. They often come to the seminars searching for explanations for their success as well as for their failures. Dr. Abraham Flexner stressed the need for a greater biologic scientific approach to the study of medicine. This may have to be blended with an increased humanistic approach. The younger physician emphasizes the somatic and microscopic basis of disease. The practitioner who graduated before 1950 has learned through years of clinical experience to develop a bedside manner based on the total understanding of his patients.

The postgraduate education of the general practitioner may need a frank reevaluation. A return to a mature apprenticeship basis may be an answer to the rigors of a continuous medical education of busy clinicians. A community intramural seminar conducted by specialists and general practitioners is a derivative of the interest that organized medicine has in elevating the standards of medical practice.

The staff feels that they have increased the knowledge of the Brooklyn physician in mental health principles inherent in the practice of medicine. They believe that this educational offering has been effective in bridging the gap in understanding between the psychiatric specialist and the medical practitioner and has enabled the latter to be efficacious in the recognition and management of the emotional problems encountered in his daily work. The success of this venture has been accomplished by the close affiliation of the local psychiatric society with the local medical society which has an active public health committee concerned with the mental health of its community.

The future of medicine, associated with the overgrowth of specialization, has produced the danger of reducing the individual to an object who goes from specialist to specialist. The patient must retain his dignity as a human being when seeking medical care. More publicity must be given to the role of the general practitioner as a coordinator and supervisor of the patient's welfare. He is actually the family counsellor, the diagnostician, and healer, be the symptoms truly an organic disease or a functional disorder. The patient may not be emotionally sick to the point of requiring formal psychotherapy from a psychiatrist, but he does need the supportive assistance of his physician. The availability of the family doctor —the "open office"—removes the fear of isolation and abandonment by the frightened patient. Thus the practitioner is basically the first step in the concept of a good mental hygiene program.

Continuing Education for West Virginia Mental Health System

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MH12742 1972–1975

Background and Objectives

The origin of the above entitled project rests in a Department of Mental Health goal of enhancing the capacity of West Virginia State hospitals to serve community mental health needs. While education and training, as ways of contributing toward the achievement of that goal statement, are not new to this agency, inherent limitations have heretofore demanded that resources for training be allocated to the nursing and care-giving functions. However, as the concept of community mental health began to make its way into the various programs and services throughout the State, a cry for altering the traditional role and function of State hospitals was inevitable.

New ways of arranging State hospital personnel were devised in order to meet this demand and while such arrangements in no way lessened the nursing and care-giving functions (indeed, patients received increased attention), the role of the physician in the State hospital as an effective member of the expanding mental health system required special attention and action. Continuing education was seen as a tool to be employed in seeking solutions to the Departmental goal and a project was devised, the activities of which aim toward improving the effectiveness of the State hospital physician as a member of the mental health team in an expanding mental health system.

Methods and Content

Employing the mechanism of a Physician Study Committee and using both formal and informal interviews with Department of Mental Health personnel, information was gathered which lead to a curriculum designed to include three broad areas of training need: planned experiences in community mental health programs outside of the State hospital; updating skills and knowledge in the treatment and rehabilitation of specific categories of hospital patients; and planned opportunities for multidiscipline team activities around live issues. Also the curriculum included refresher activities in the basic and clinical sciences which the physicians felt would be most helpful to them toward attaining the privileges of full licensure. A certain strategy was also employed to relate the physician training project to the hospital staff development program by means of planned effort to bring a certain sophistication in the area of program planning and development to the hospital unit team level in the changing mental health system. The two programs will converge during the third year with multidiscipline team activities.

The project is just beginning (July 1972) and organization work at best is difficult. Nonetheless, during this time interval, a joint hospital-community mental health centers committee was established to plan, develop and monitor the community phase (1st year) of the project. This committee has submitted a tentative training proposal to the West Virginia Medical Licensing Board. The proposal utilizes two nearby community mental health programs as training sites. Physicians from the State hospital, under competent guidance, will receive varying experiences in six areas of activity or function described by the committee as relating to the effectiveness of a physician on a mental health team. The functions are identified here only as direct services, consultation, coordination, survey and orientation, records and reports, and training. Parenthetically, these terms are not unlike those independently employed by the Physician Study Committee during an effort to get at training needs by a job analysis survey.

Instructional staff is currently being sought to develop specific content and methods for a series of complementing seminars during which time physicians may share experiences and a theoretical input offered from the fields of medical care administration, biostatistics, epidemiology and community organization. The seminar/workshop series represents 7½ days of a total of 34 days allocated to the community phase of the continuing education project.

No details are available for satisfying the training needs scheduled for the second and third years of the project. As the efficacy of the organization unfolds and when long standing wishes for training turn into actual training experiences, rapid strides toward these matters are expected.

Students

The trainees are all staff physicians in the State hospitals of West Virginia. Some 54 in number, the project will focus on one hospital with 15 physicians on staff. The trainees are foreign born and graduates of foreign medical schools, although many have had additional training in this country. The trainee group has been in the United States about 3 years with the majority indicating the Philippines as their country of origin.

Program Evaluation

With one exception, specific evaluative schemes have not yet been developed. The exception is a form adopted by the joint hospital-mental health centers committee to assess the adequacy of the training experience at the centers in terms of the six areas of activity or function of the physician as a member of a mental health team. Both trainee and site staff will complete the assessment.

In general, two evaluative thrusts are being considered . . . one, having to do with the efficacy of the organization determined essential to develop and monitor the details of the training within the three broad areas of the curriculm, while the second would deal with the effectiveness of the program itself. Despite its shortcomings the method of impressionistic observation has been determined to be the chief evaluative tool to avoid the risk of detracting from the training and involving an unqualified staff with but limited resources from embarking on an evaluative research into cultural, behavioral and organizational change. The importance of such an inquiry is not to be denied but is simply outside the capabilities of the project staff. Peer group evaluative techniques will be used for interpersonal feedback as well as democratic course changes and development.

Paralleling an existing training effort may not appear to be the most innovative or efficient route to a common goal . . . an effective mental health team serving community mental health needs. The strategy was developed from many years of experience during which it was observed that the meeting room does not possess a mystical quality for generating wisdom when crowded with people coming there to meet and converse. On this basis the Department of Mental Health has made plans to continue the project subject to evaluative efforts noted. These plans include incorporating the project staff of three persons into the Departmental budget at an early date in order to extend the re-planned program into other hospitals in the mental health system of West Virginia.

Psychiatric General Practitioner Postgraduate Education

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MH08582 1964–1974

Background and Content

For the past 8 years, Mercy Hospital has conducted a program of continuing education in psychiatry for the nonpsychiatric physician. This has been presented in the Psychiatric Department of this 400-bed suburban, voluntary general hospital with both inpatient and outpatient psychiatric facilities. The course has evolved into one of 80 2-hour per week sessions. The program stresses applied clinical psychiatry based on theoretical formulations. This is exemplified by the curriculum whose opening sessions deal with psychodynamics, normal childhood development, emotional problems of childhood and adolescence. It subsequently covers drug abuse, alcoholism, suicide prevention, family therapy and problems of the underprivileged. The neuroses, personality disorders and the psychoses, which include the schizophrenias, manic depressive psychoses and the organic brain disorders, complete the first year's coverage. The focus of the second year is on improving the technique of interviewing, diagnosing and treating. This is done by means of a preceptor-student format of live case supervision. The diagnostic categories stressed are depression, schizophrenia, psychophysiological disorders and family therapy.

In dealing with areas of special pertinency to psychiatric problems of the underprivileged, black psychiatrists, with experience in these areas, have conducted sessions jointly with white psychiatrists. For its renewal period the program has developed a course in consultation with black physicians, which, in addition to the above, will stress the recognition and management of the psycho-social aspects present in the multiproblemed families of the black ghettos. Sessions will be conducted jointly by black and white psychiatrists; public health nurses, psychiatrically trained by the program and involved in health care of the underprivileged, will assist in selected presentations.

Students

The enrollment consists of 10 basic and 9 advanced students. Their specialties include 15 general practitioners, one pediatrician, one surgeon, one neurologist, and one internist. In the past, the trainees have maintained an 80 percent attendance record.

Roughly half of the enrollees have previously participated in other short-term, nonhospital based seminars. Repeatedly in evaluation sessions, they have emphasized their strong preference for the live case presentation method of teaching.

Evaluation

A number of evaluation techniques have been utilized, including: (1) a closed-end, graduated response questionnaire, regarding trainees' assessment of the course effectiveness in certain targeted areas; (2) a pre- and post-course semantic differential questionnaire aimed at bringing out attitudinal changes; (3) hour-long, in-depth, open-end taped interviews; (4) open-end evaluation discussions with the trainees; (5) faculty discussions regarding the attainment of course goals, methodology and content; and (6) one of the faculty members, a full-time Professor of Psychology, has acted as our Education Consultant and sits in with the class periodically for evaluative purposes.

Over the past 9 years the program has reached into the psychiatric community for a core of sub-specialty instructors. The program now has what they consider to be a top level faculty.

The Restructured Program

In order to better utilize the instructors and to give the program greater cohesiveness, the program has been restructured. Each presenter will now have sufficient time to develop his topic adequately. This has been made possible by visualizing the course as a 2-year program thereby enabling staff to devote a more appropriate number of sessions to each topic. In addition, this has enabled the students and preceptor to be together over a sufficiently longer period to develop a working relationship.

Starting in the second year, the cases to be presented will be interviewed by the students. In the subsequent discussion, both the topic, e.g., depression, and the interviewing techniques will be considered.

It is to be noted that the above changes are a modification of the program as presented in the initial paragraph.

During the past year the Department of Psychiatry, Health Science Center at SUNY, Stony Brook, became a cosponsor of the program. As a result, this program is being used as a basis for a 2-year course in psychiatry for Family Physician Residents to be given by the Department of Family Medicine.

The Community Mental Health Board of Nassau County has approved for reimbursement the utilization of trainees, who have completed the course, when they function as part of the psychiatric team in a supervised setting. At the present time five are so functioning at the Mercy Hospital Psychiatric Clinic.

As a result of the impact of the program on the Psychiatric Department of Mercy Hospital, it has become strongly teaching oriented and currently the Program Director is also Director of Psychiatric Research, Teaching and Education at the Hospital. He is responsible for the following: Psychiatric Education for Nonpsychiatric Physicians; Public Health Nurse Psychiatric Home Visiting Program; Psychiatric Education for Interns; Social Work Internship Program.

The staff has been most cooperative and

there has been no problem recruiting both members of the hospital staff and outside consultants as faculty members.

The program's emphasis on hospital based psychiatric programs for nonpsychiatric physicians has been endorsed by the Nassau District Branch of the A.P.A. A representative of the American Association of Family Practice has acted in a consultant capacity in the formulation of the course and as a result, the program has been certified for 80 postgraduate credit hours per year.

It is too early to make any definitive statement regarding the interaction of black and white physicians and psychiatrists, or the impact this program might have in the area of interracial problems. There has been an overt willingness, however, to partake in discussions regarding social problems. Group dynamics seem to be going in a direction where all are comfortable in discussing interracial problems.

Psychiatry–GP–Postgraduate Education

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MH07665 1961–1974

Background and Objectives

Our educational program is entitled, "Psychiatric Training for the Nonpsychiatric Physician." The objective is to impart useful and practical knowledge and psychiatric skills to the nonpsychiatric physician who is dealing with psychiatric problems in his everyday practice. The instructors are fully trained psychiatrists, and the students are nonpsychiatric physicians—primarily family practitioners, but also included are members of various other specialty groups.

The sponsoring organization for the training program has been the Minnesota State Medical Association. In this organization is a committee on mental health and a subcommittee concerned with psychiatric training for nonpsychiatric physicians. The program director and assistant program director are members of both of these committees and meet on a regular basis throughout the year. In addition, there are periodic meetings between the program director, assistant program director, executive secretary of the Minnesota State Medical Association, various instructors, and also a representative from the field of general practice who is active in the American Academy of Family Practitioners. This type of policy allows for the policymaking and decisionmaking process in a flexible way with optimal communication between all parties involved in the training program. In addition, a good deal of decisionmaking is left to the individual course instructors as to content of course material and how the course will be conducted. This, in turn, is dependent upon a good amount of feedback from the students involved in an informal manner. This has proved to be a workable plan in the past and has allowed for a flexible training program that has been well received by the vast majority of participants.

Methods and Content

The primary training method used has been that of a didactic lecture, although with a great deal of flexibility that allows room for much discussion and seminar-type interchange. From time to time other modalities are used, such as movies and demonstrations that would involve actual patient interviews. The courses are given in sessions of 2 hours each on a weekly basis for a period of 12 weeks, bringing the total course hours to 24 for each course. This has remained flexible and has been modified on occasion to suit specific scheduling needs of the students involved.

Course content includes some basic information concerning psychiatric diagnostic nomenclature and organization, as well as information about psychotropic medications. A wide range of topics are also included on a flexible basis at the request of the specific student groups. These topics tend to be common problem-type situations which are seen in the everyday practice of general medicine. Included would be such things as marital counseling, counseling in sexual problems, drug and alcohol abuse, treatment of acute psychiatric emergencies, assessment of suicidal risk, treatment and assessment of depression, and management of difficult patients.

Program Evaluation

Program evaluation has included both formal and informal feedback between students and instructors and between the sponsoring State Medical Association Office and the program directors. The program has basically remained the same since its inception, although the flexibility in terms of course content has made the program a continuously variable type of training situation.

Psychiatry–GP–Postgraduate Education

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MH07099 1960–1973

Objectives

The educational objective is to train primary physicians (internists and pediatricians engaged in a group practice setting) to diagnose and manage the psychological problems presented in patients with organic illness, in neurotic patients and in the occasional psychotic patients seen in office practice.

Methods and Content

The group met for 1½ to 2 hours every Monday during the duration of the program. Patients were interviewed for 20–25 minutes behind a one-way screen. Following the interviews, a psychiatrist led a discussion aimed at evaluating the technique and emphasizing what was learned about the patient and his disease during the interview. Patients were interviewed at regular intervals over a period of years to follow the progress of certain problems. Other methods employed were didactic lectures and seminars on specific topics.

Intensive attention was paid to the following topics: (1) psychosomatic illness—ulcerative colitis, peptic ulcer, bronchial asthma—to correlate the course of the illness with major events in the patient's life; (2) care of the dying patient, with specific emphasis on the patient with cancer; (3) the impact of chronic illness on the immediate family—when a child is the patient, and when one of the parents is the patient; (4) family therapy in cases where the patient had physical illness with many related emotional problems; and (5) the effect of life-threatening disease on the patient and his family (mainly those with acute myocardial infarcts) by following the patient from initial admission to the intensive care unit through hospitalization, convalescence, return to previous work or retraining for other work, to observation of progress at 6-month intervals, with an effort made to assess whether any significant event or events occurred at the time of the coronary.

When the program started in 1960, the physicians were all employed in a prepaid program covering 25,000 Hospital Improvement Project patients. In addition to the normal stresses and strains of doctor-patient relationship, there was the problem of the patient's attitude of making sure he was getting all the services he had coming to him and the doctor's defensive attitude about his prerogatives. As a result, charts showed too many X-rays, too much laboratory work and too many consultations.

Students

During the first few years the program was geared only for internists and pediatricians who worked in the Montefiore Medical Group. In the past few years, however, it has been opened to nurses in the ambulatory services, residents, interns and medical students, social workers, and psychologists, all of whom work in Montefiore Hospital. The program was still directed to training physicians, and the remainder of the students were present as observers. Therefore, the core of students consisted of 15–20 members, with about 15–20 observers. Since the program is associated with a large hospital and medical school, the potential trainees could encompass all the physician and nonphysician professionals and paraprofessionals; i.e., everyone who has any direct association with patients.

Program Evaluation

The program had two psychologists who

were charged with evaluating the impact of the program on the patient and on the physician. Various techniques were used—questionnaires, direct personal interviews with the patient and the physicians; and an adaptation of a role-playing instrument devised by Dr. R. Heine.

It rapidly became clear that there could be no statistical evaluation. It was agreed that there was no simple way to determine the effectiveness of the program, but both of the psychologists and the physician involved were of the opinion that physicians, nurses, social workers, etc. (other than psychiatrists) could be trained to deal with the problems outlined in the objectives.

Program personnel felt that this can only be taught by demonstration and participation and not by didactic lectures. The program also must be relatively long term because it is not a matter of incorporating data or memorizing facts, but is a matter of learning to listen to what people say, to become more sensitive to hints they throw out, to become more intuitive about people in general. Because most internists and pediatricians are taught to deal with disease and symptoms and not with people, it means development of a new set of reflexes without discarding any essential part of the training in diagnosis and management of organic disease.

All participants agree that many of the objectives have been attained through the years. The success of the group—now non-prepaid—is in a significant measure due to this program. More important, since the program serves a large geriatric population—admittedly patients who have the most chronic, difficult problems—it is very well suited to understand and cope with their emotional as well as their physical needs.

The program is moving very rapidly to integrate the entire outpatient department in the hospital with the group—at least in style if not in fact.

Although this training program is not known throughout the community, what is very well known is that the physician in the group provides excellent comprehensive human care. The program already has created a general medical clinic where the resident is the primary physician. In the group and in the clinic the program is devising a team approach where all the personnel involved with the patient will become a cohesive team—doctor, nurse, social worker, family health worker, receptionist—and the patient will form a team with the group working in tandem in the office, home and hospital to develop comprehensive whole care of the patient. The training program is a natural for these teams. The physicians from the group, who are already trained, will become the teachers. The aims are the same but will be adapted to fit the team instead of the individual physician. Although new innovations and new approaches undoubtedly will be used, the main objective will remain the successful treatment of the entire patient and his family.

This program can easily be adapted—as it is now being done in many places—to individual doctor's offices, to groups, to outpatient departments. It works because it fulfills a definite need. There are not, and there never will be, enough psychiatrists to take care of the emotional needs of the patients. Also, it is more appropriate for the primary physician to be able to deal with the patient and not just his illness. This program has definitely fulfilled this need, and the technique can be taught, not only to other physicians, but to other professionals and paraprofessionals involved in patient care.

Psychiatry–GP–Postgraduate Education

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MH06939 1959–1973

Objectives

The general objective of the Nebraska Psychiatric Institute's continuing education program, General Practitioner Postgraduate Education, is to improve the mental health care of the citizens of Nebraska, especially those persons living in rural areas where mental health facilities and mental health professionals are scarce. This objective is met through increasing the interest, knowledge and skills of family physicians in those areas in the diagnostic evaluation and clinical management of mental illness.

Trainees demonstrate growing ability to provide their patients with more and better psychiatric care by meeting several specific objectives as evidenced by (a) a willingness to accept, evaluate and, when possible and appropriate, treat variously referred psychiatric patients; (b) recognition of a possible mental illness in patients not making a specific psychiatric complaint; (c) ability to conduct a psychiatric interview so that data can be collected for an adequate mental status examination; (d) ability to make correct diagnosis and evaluate need for further diagnostic studies or consultation; (e) given a diagnosis, the ability to outline an appropriate course of treatment; (f) ability to conduct long- and short-term therapy and make appropriate use of psychotropic medications; and (g) ability to select from a group of patients, taped interviews, or case histories, those patients who can be treated as outpatients and those who may need hospitalization, and ability to discuss the need for hospitalization with the patient in a manner conducive to obtaining voluntary admission. A specific objective for consumer benefit is provision by family physicians of psychiatric services that were previously unavailable in vast areas of the State.

Methods and Content

The methods of training and the content of this program have four main components:

1. An ongoing course, "Office Psychiatry for Family Physicians" in which participants come to the Nebraska Psychiatric Institute for 12 monthly all-day sessions (making up any that are missed) and, in addition, spend at least 4 hours per week treating psychiatric patients who would not otherwise have ready access to mental health care. Priorities are given to disadvantaged persons from low income or minority groups, to patients living in areas without nearby psychiatric practitioners or clinics, to patients referred by the Nebraska Department of Public Institutions' satellite clinics or Comprehensive Community Mental Health Centers, and to aftercare patients from Department of Public Institutions facilities. Each monthly meeting begins with a participant interviewing a patient selected to illustrate a particular problem, followed by a group discussion of the interview, lectures, film showings, the distribution of instructional materials, and seminar discussions, all related to the problem. Another patient is interviewed in the afternoon, followed by discussions of patients in treatment. Session themes cover the full range of psychiatric problems encountered by family physicians, with office psychotherapy and psychopharmacology treated not as separate themes, but as ongoing considerations for each session.

2. Grass Roots Clinics are held in small communities throughout the State, based on requests from local physicians. A multidisciplinary team from the Nebraska Psychiatric Institute spends a full day conducting each clinic, the theme of which is decided by the local practitioners according to the type of case that is of special concern to them. Participants select two or more patients to be seen and evaluated by team members and discussed with the group. They also present problems concerned with other cases in their practices. The cases are then discussed, emphasizing treatment planning. These clinics have been held twice a year but plans have been made to increase this number to 12 per year.

3. Traditional 1 or 2 day Postgraduate Courses are offered one or more times yearly, in Omaha or elsewhere in the State. These are planned in collaboration with the Department of Family Practice and the Division of Continuing Education. Topics of broad general interest, chosen on the basis of suggestions from participants in the other phases of the program, are presented in a workshop format. Experts in the field serve as speakers and panel participants, alternating formal presentations with small group discussions.

4. A Telephone Conference Service is available to provide assistance to rural practitioners in the management of psychiatric patients.

Throughout all phases of the program, the decisionmaking process in program planning and implementation is an ongoing activity, taking into account the expressed needs of the family practitioners of the State, the recommendation of present and former course participants, and recommendations from medical organizations. Goals and objectives are set by the project staff in consultation with the faculties of the Departments of Psychiatry and Family Practice and the Division of Continuing Education of the University of Nebraska College of Medicine and the staff of the Division of Medical Services of the Nebraska Department of Public Institutions.

Students

Students in this program are family practitioners, primarily from rural areas of Nebraska. For the most part, these are general practitioners, holding the M.D. degree. Osteopathic physicians may be accepted, and medical specialists in fields other than psychiatry (e.g., internists) are not excluded if they render primary care. Approximately 14 physicians per year participate in the course, "Office Psychiatry for Family Physicians." Attendance at the Grass Roots Clinics averages six, so that 12 sessions in different communities during the year will reach about 72 physicians. Short courses or workshops have an attendance of 50–100. While priority is given to physicians from rural areas, physicians from urban areas may be accepted if their practice includes a significant number of disadvantaged, minority group, or aftercare patients. Physicians from adjoining States that lack similar programs may be accepted in the future.

Program Evaluation

Program evaluation has several components. Participants in all phases of the program evaluate it in terms of relevance, content, and educational methods. Attitudes toward treating psychiatric patients are assessed before and after the year-long course. Factual knowledge of psychiatry is tested before and after course participation. The degree of achievement of behavior objectives is evaluated comparing pre- and post-course performance, utilizing videotaped interview evaluation. The amount of time devoted to psychiatric practice and the number of patients seen are studied by a survey of former, present and potential participants to see if more psychiatric care is given and if it continues to be given. Statistical information on hospitalization, rehospitalization, and other indicators of mental illness will be studied.

This program has great potential for replication in other areas. It could be carried wherever adequately trained staff and teaching facilities are available. The community impact of this project is, and will increasingly be, that the family practitioners' knowledge of psychiatry and comfort in dealing with psychiatric patients afford more people prompt treatment, and fewer people will have to leave their communities for treatment at regional mental health centers. Recent changes in the program have been an increase in the number of Grass Roots Clinics and an increased emphasis on interview techniques and other methods of information-gathering, utilizing videotape during the monthly sessions.

Major strengths of the program are the well-trained staff and the excellent facilities of the Nebraska Psychiatric Institute. A weakness of the project is that recruitment is sometimes difficult due to the potential trainees' heavy workloads and their initial discomfort in dealing with psychiatric patients.

This program is an innovative approach to continuing mental health education because it is a continuing, repetitive, comparatively long-term educational experience which affords an opportunity for the family physician to make a significant change in his knowledge and attitudes toward a specific type of patient.

Psychiatry–Physician Education Project

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MH10445 1966–1974

Objectives

The general objectives of this training program are the prevention of mental illness and the treatment of individuals with emotional problems in their home communities. To meet these broad goals, the program seeks to assist physicians increase their awareness of mental health concepts and develop skills that can help them deal effectively with people who have emotional problems. Mental health specialists provide specific new information and consultation in the area of psychiatry to physicians, in a one to one relationship as close to a physician's home practice territory as possible.

Methods and Content

In three diverse geographic catchment areas in North Carolina, mental health specialists are providing consultation-education to primary physicians. This is provided by the specialists at the physician's office, at the hospital or any other locality the primary physician designates.

Specific content areas are initially determined by the primary physician. These consistently have had to do with the usage of drugs and diagnosis of emotional problems. Further content areas developed include interpersonal relationships, family and group process, psychiatric diagnosis and management.

There is no prescribed time sequence or total course hours. The goal is to establish an ongoing relationship with the primary physician at an interval suitable to him. This has meant that for some physicians meetings have occurred once every week while others might have met once every month. Meetings have continued over a course of at least a year.

Students

Students have all been physicians of varying categories, including general practitioners, pediatricians, surgeons, obstetricians, and internists. The total number is now over a hundred.

Characteristics of trainees have varied. Some of them are reasonably recent graduates while others have been in practice for many years. In two of the settings, the predominant student has been the general practitioner; while in the third setting, the predominant student is a specialist of some category.

Program Evaluation

Evaluation has been multiple and has included patient statistics on referrals to mental health centers and to the State mental hospitals serving the areas. There has been a process evaluation which has described the interactions between physicians and educators. An intensive evaluation has been undertaken over the past year, in which specific questionnaires were developed and administered to all physicians in December 1971 and again during December 1972. The questionnaire was designed to measure the physician's approach to typical problem cases, and included brief histories to which the physician was to answer concerning ideology, clinical impression, diagnosis, treatment, and knowledge of community resources. The social distance and social responsibilities scale was used to measure attitudes toward mental illness. A group of 10 psychiatrists who had been in practice for at least 10 years in North Carolina was used to validate the questionnaire. Contributors in the evaluator admission process included trainees, staff and validating psychiatrists.

The project staff consider this program to be highly replicable, particularly at local levels, and that it should be integrated as a portion of every comprehensive community mental health program.

Community and organizational impact of the project has been extensive. In all three communities, there has been a decline in admissions to State hospitals. Specifically, psychotic reactions, depressions, and chronic brain syndromes have been most affected. In all three communities, there also has been a significant increase in the numbers of patients being treated at the local general hospital. In one of the areas where alcoholism was a specific content focus, a very successful detoxification program has been established without the presence of a full-time psychiatrist and without the presence of a discrete psychiatric unit in the general hospital. At this time, plans are being made to incorporate this type of service in all area mental health programs of the North Carolina Department of Mental Health.

The major strengths of this project are that it meets the trainee at his site and attempts to provide the knowledge and assistance that he feels are needed to accomplish those tasks with which he is confronted. The project utilizes the trainee's own work situation and work problems as material. It relies heavily on the one-to-one approach, making it possible to individualize the program. There is no particular limit in terms of hours to the number of transactions, consequently, a long-term relationship can develop.

The program is considered to be innovative because it brings psychiatric education to the physician where and when he needs it, rather than asking him to absorb psychiatric jargon presented in a pre-cast mold.

Psychiatry–GP–Postgraduate Education

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MH07402 1961–1974

Objectives

On the basis of a survey of the literature, the committee for continuing education in the Department of Psychiatry decided that the purpose of this continuing education program in psychiatry for nonpsychiatric physicians gain more insight into the psychological problems of their patients, provide better treatment for these patients, and handle the doctor-patient relationship in a more effective way.

The specific objectives of this program were to: (1) begin a new continuing education program in the Department of Psychiatry in the School of Medicine at the University of North Carolina; (2) assess the interest of local medical societies in continuing education in psychiatric topics for nonpsychiatric physicians; (3) reach as many nonpsychiatric physicians in the State as the time permitted with a seminar series in psychiatric topics chosen by physicians of local medical societies; (4) allow physicians to select topics, time, etc., to control their own seminars; (5) evaluate the success of these seminars so that the data could be used to plan the next 2 years of the project; and (6) gather demographic data on the kind of physicians in North Carolina who were interested in continuing education in the area of psychiatry.

Methods and Content

Each seminar series was planned and controlled by local physicians. A faculty member from the Department of Psychiatry of the University of North Carolina was asked to prepare a seminar on a topic selected by the trainee group and to present the material in the manner in which the local physicians had chosen, e.g., lectures, group discussion, case discussion and group discussion, or group discussion and didactic lectures. This faculty member then traveled to the location chosen by the local physicians and participated in the seminar series. The number of meetings and the topics varied from county to county.

The specific content areas chosen by the local physicians were: management of the emotionally difficult patient, terminal illness and the dying patient, counseling in marital and sexual problems, indications and considerations in abortions, depression and suicide, treatment for alcoholism, behavior problems in adolescence, and drug abuse prevention and treatment.

The time sequence and total course hours for each seminar series varied but the following is an example:

The local physicians in Moore County chose the topics of terminal illness and the dying patient and counseling in marital and sexual problems. Two hours were devoted to each of these two topics in the seminars. Management of the emotionally difficult patient, behavior problems in adolescence, management in depression and suicide, and counseling in marital and sexual problems were the topics chosen in Guilford County. One and one-half hours were spent on each of those topics, with the exception of counseling in marital and sexual problems for which 2 hours were used. One and one-half hours were spent on each of the four topics chosen in Sampson County: indications and considerations in abortion, management in depression and suicide, management of the emotionally difficult patient, and treatment in alcoholism. Three hours were used for the seminar on drug abuse prevention and treatment in Chatham County.

Students

All trainees in this project were M.D.'s, in the following specialties: obstetrics and gynecology-3, opthomology-1, pediatrics-3, pediatrics surgery-1, family practice-19, radiology-2, orthopedic surgery-1, orthopedics-1, general medical and surgery-9, internal medicine-2, emergency room-1, public health-2, psychiatry-4, and pathology-1.

General characteristics noted were that 75 percent of the trainees had been in practice in the present community more than 5 years, and less than 1 percent was below the age of 35. Individual private practice and group practice were the modes of practice for most of the participants. The median number of patients seen in a typical day in practice was 20–29. Seventy percent of the trainees sometimes refer patients with emotional difficulties to psychiatrists. A similar percentage said they referred patients with emotional difficulties to mental health centers and/or clinics. Sixty-six percent of the trainees said their informal discussion with their medical colleagues infrequently focused on emotional disorders. Seventy-five percent had never participated in any postgraduate seminar or course in psychiatry. Of the 25 percent who had participated in a postgraduate course or seminar in psychiatry, one-half said it had been at least 5 years previous.

The population of potential trainees would include nearly all the physicians in the State of North Carolina. Because of the limitations of time for the past year, this project was limited to counties in the central Piedmont region of the State.

Program Evaluation

The first portion of the evaluation of this process assessed the needs of the physicians, and the data served as the basis for the structure of the entire program. In order to evaluate the educational process of the seminars, two instruments were developed.

A demographic questionnaire was given to each participant as he entered the seminar room. Such facts as the number of years in practice, age, type of practice, number of patients seen daily, referral patients, extent of psychiatric training, and motivation for enrollment in the postgraduate seminar were collected via this questionnaire. A post-seminar questionnaire was also used for each physician. This included an overall evaluation of the seminar, several estimates of the presentation of the particular instructor, and the opportunity for the participants to make any comments about the continuing education program. The entire evaluation process was done by the trainees.

This program is now being replicated on a larger scale in the entire State by the Department of Psychiatry at the University of North Carolina. The primary community impact that this project has had to date is that several physicians have reported that they wished to have a similar seminar series in their community and that they like being able to determine the content and time and place of the seminar. Referral of patients into the inpatient psychiatric facilities of North Carolina Memorial Hospital, the teaching hospital of the Medical School of the University of North Carolina, has been facilitated by the personal contact that the local physicians had with the faculty members of the Department of Psychiatry via this project. Plans are presently being implemented in which the North Carolina Department of Mental Health and the North Carolina Academy of Family Physicians will cooperate with this project in sponsoring continuing education programs for the practicing physician. There is increasing evidence that the faculty of the Department of Psychiatry are becoming more aware of their responsibilities to the practicing physician as well as to the need to better coordinate the psychiatric resident training program with the needs of the community.

The major strengths of this project are that it is controlled by the consumer, i.e., the local practicing physicians; that the basic design is flexible enough to allow for programs which satisfy the needs of the practicing physician; and that the program takes place in the community of the physician—where he works and lives. The major weakness of the project is that the consumer orientation and decentralization approach of the project necessitates a relatively great amount of administration time and effort.

Psychiatry–GP–Postgraduate Education

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MH11063 1967–1973

Objectives

The Ohio Academy of Family Physicians Continuing Education in Psychiatry (OAFP-CEP) was organized through the joint efforts of the Ohio Psychiatric Association, the Ohio State Medical Association and the

Ohio Academy of Family Physicians, to improve patient care by perfecting the skills of primary physicians in dealing with their patient's everyday emotional problems.

The long-term goal of the project is to expose at least 1,000 practicing physicians in the State of Ohio, over the next 10 years, to indepth training seminars aimed at helping them to sort out the type of emotional problems with which they are dealing, through improved interview technique and diagnostic skill. Having recognized the problem, the second objective is to make the practicing physician more comfortable in providing continuing support and care to those patients whom he himself can manage. Emphasis is placed on helping them to better detect those patients who should be referred for specialist psychiatric care. An effort is made to make the practicing physician more comfortable in teaming with his local psychiatrist and mental health facilities for the overall mental health care of his patient. At the same time, psychiatrists involved in the training seminars as consultants become more aware of the nature of primary emotional illness and of the problem this presents to primary physicians.

Special seminars are offered to give emphasis to problems of adolescents, drug abuse, alcoholism and suicide. Family counseling, sex education and marital counseling also are included in special training sessions.

Methods and Content

With these objectives in mind, the initial Seminars in Patient Care were organized to meet in groups of 10 to 15 primary physicians, with a family physician moderator and a consulting psychiatrist. Although there have been a number of variations, training is centered about live patient interviews followed by group discussion of the patient's problem and future management, plus a critique of the interview technique employed. Generally, patients are private patients brought in by members of the group and are usually interviewed by a physician other than the patient's own family doctor. Some patients have been obtained from outpatient services in community health centers and community hospitals.

No rigid curriculum is adhered to; however, the following curriculum outline is distributed to the seminar moderators and consulting psychiatrists as suggested specific goals to be covered as the individual patient interviews permit: (1) interview techniques and practice interviews, (2) discussion of patients currently presenting problems in the doctor's own practice, (3) differential diagnosis, (4) psychiatric emergencies, (5) office treatment of depressed patients, plus when to refer and when to hospitalize, (6) indications and contraindications for psychiatric referral—working relationship between psychiatrists and nonpsychiatrists, (7) brief therapy techniques and their basis, (8) use and abuse of psychiatric drugs, (9) principles of prolonged supportive therapy and maintenance therapy of psychotic patients' posthospitalization, (10) setting goals of therapy, (11) counseling on sex and marriage, (12) proper utilization of community mental health resources, (13) the economics of psychiatry in everyday practice, and (14) management of the hospitalized patient.

Consulting psychiatrists and seminar moderators are encouraged to avoid material concerning the hospitalized psychotic patient or patients with chronic psychosis. They are admonished to include as few "dead" cases or "impossible" cases as possible. Experiential learning without any content or agenda, and subspecialty psychiatric techniques such as group psychotherapy, psychoanalysis and techniques of shock therapy are avoided.

Variations to this basic approach include the use of closed circuit television, loaned to the seminar groups by the State project, to permit the individual physician to confront the patient privately with the dispassionate eye of television looking on, and to provide the entire group with the opportunity to critique the interview technique via the television monitor. The same goals still pertain. An additional advantage is that the viewer has an option to observe his own technique. Interview rooms with one-way mirrors are utilized when they are available. Training films in interview technique and nonverbal communication are likewise utilized to enhance the curriculum on occasion.

Originally, the seminars were planned to extend over a period of 30 weeks a year for a total of 2 years, which totaled 120 hours training at the rate of 2 hours per week. Such indepth experience produces an actual change in the practicing physician's skills and approach to patient's emotional problems somewhere early in the second year. Currently, seminars are being recruited in increments of 10 weeks for a total of 30 weeks per year or increments of 12 weeks for a total of 24 weeks per year. No shut-off is being maintained at the end of the second year. Hence, several of the courses are continuing into their fourth, fifth and sixth years. Courses are still averaging 1½–2 hours a week.

The decisionmaking process on a week-to-week basis is the responsibility of the Program Director who is, himself, a practicing family physician selected by the Board of Directors of the Ohio Academy of Family Physicians. He presides over the Council of Directors which is composed of the State Psychiatric Advisor and all the consulting psychiatrists in the seminar groups as well as all of the family physician moderators involved in the project. The entire Council of Directors meet on an annual basis at the time of a Teaching Skill Workshop weekend, which is of benefit to both the consulting psychiatrists and the family physician moderator.

Students

The vast majority of trainees in OAFP-CEP are members of the Ohio Academy of Family Physicians. These doctors have prior orientation to continuing postgraduate medical education because of the fact that membership in the Academy is predicated upon the completion of 150 hours of continuing postgraduate medical education every 3 years. Otherwise, membership is dropped. The most keenly interested group of members interested in the seminars in patient care are those physicians who graduated from medical school over 15 years ago. However, many of the younger physicians currently are expressing more interest. Most of the physicians have had no previous formal training in psychiatry. Most have had only a rotating internship. A few have had some residency training in a specialty other than psychiatry.

All physicians practicing primary medicine have been invited to join the seminars and a number of these have complied. Specialists represented are internal medicine, otolaryngology, obstetrics and gynecology. Increasing interest is being expressed currently by residents in family practice and a few of these are being added to our seminar groups. Also, a few doctors of osteopathy are currently being enrolled.

Program Evaluation

Since the inception of the program 6 years ago, OAFP-CEP has conducted a regular program evaluation under the direction of an evaluation psychologist. Annually, a questionnaire is submitted to each of the seminar participants for a self-assessment. This past year, the physician's office personnel were interrogated by mail questionnaire as to their opinion of the affect of the seminars on their employer. Site visits by the program director, as well as the State psychiatric advisor and the evaluation psychologist, are being utilized increasingly for evaluation.

The responses of the seminar participants on their questionnaires indicate an overall satisfaction (91 percent) with the seminars. Fifty percent of the respondents felt that the most useful part of their training was learning how to interview their patients more effectively. Seventy-four percent said they would like to attend another CEP course similar to the one just taken; 58 percent had recommended the seminars to other colleagues and 42 percent offered to serve as moderators in future seminars. As for changes in the participants' feelings about handling the psychological problems of their patients, only 12 percent reported no change, whereas most felt that they were more interested, more willing to deal with the problems and more able to see the problem. The specific psychiatric problems listed most frequently were anxiety and depression and psychosomatic disorders. There was an 88 percent overall satisfaction with the consulting psychiatrists.

In the opinion of the CEP Council of Directors, the forte of the project in Ohio is the fact that it is not administered by psychiatrists nor promoted by the psychiatrists to the primary physicians. It is felt that successful acceptance is due to the fact that peer administration and peer recruitment are within the family practice structure. There is nothing about this project that could not be replicated by other States through their own Academy of Family Physicians provided their State Steering Committee would permit such an orientation in administration.

The impact of the project to date is difficult to assess. The psychiatrists involved in the project believe that the primary physicians who have received CEP seminar training generally are doing a better job of managing their patient's everyday emotional problems and, because of their ability and comfort in dealing with them, are referring fewer cases to psychiatrists. Moreover, those selected for referral more uniformly do require special psychiatric care. The earlier detection of mental illness has been enhanced. Finally, the program has noted greater availability of physicians in outlying communities to supervise the post-hospital care of patients discharged from mental health centers, who are returning to communities where no psychiatric care is available.

The format of the OAFP-CEP has been continually updated by the curriculum workshops which have been held. The first major change in format was from a rigid didactic curriculum published at the outset to the current problem list which is covered only as the actual patient interviews in the groups permit.

The major strength of the OAFP-CEP Project comes from its having been organized basically within a group of family physicians by those within this group who felt they had a considerable need for further training in this direction. The general awareness of this need and the willingness of the family physicians to continue to recruit from within their group has ensured the continuity of the project's success.

Psychiatry–Postgraduate Education

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MH08590 1964–1974

Objectives

This course is designed to enhance the practicing physician's skills in the recognition, management, treatment and referral of patients with emotional problems and psychiatric illnesses. The design of this course (a longitudinal didactic and practicum experience) offers the physician a continuing opportunity to develop skills in helping and understanding any patient.

The didactic goal is the acquisition of adequate knowledge in the area of descriptive psychiatry, psychopathology, personality growth and development, and treatment modalities. Short "tests" are given in these areas by having the physician respond to an audiovisual tape example of a depressive reaction. Each member of the class responds to the material in terms of diagnostic impression, dynamics of the disorder and suggestions for treatment or management. Another specific objective is that the physician experience his role as a doctor differently. This difference can best be conceptualized as the physician learning to negotiate contracts with his patients except in the emergency situation. While changes in this area are difficult to evaluate, most (82 percent) of the physicians state that they get more satisfaction from their practice and enjoy their patients more. Another specific objective is to give the physician an opportunity to work with other professionals; to implement this, nonphysicians have been in the class the last 4 years. Dentists, ministers, social workers, nurses, housewives and psychologists have been included.

Methods and Content

The methods and content are continually evolving; the first 6 months of the course are focused on basic psychopathology, treatment modalities and personality structures. The evolvement of this part of the course has been facilitated by faculty members using feedback from previous participants in previous years. (The first year course meets weekly for 4 hours of classwork; additionally, consultation and supervision for individual problems and cases from their practice are provided by faculty members, Department of Psychiatry.) After 6 months, each class determines the format for further experiences. What has evolved in Continuing Course I, is a curriculum which focuses on case studies of specific interest to the class. Twenty-five members of this group have continued to participate, some for 7 years.

The specific content area for this Continuation Course for the past 2 years has been: human sexual inadequacy, principles of family therapy, death and the dying patient and separation anxiety. Four monthly sessions, 5 hours in length, have been spent on each of these subjects. A physician from the group brings an appropriate patient and/or family to the conference and a consultant discusses with the group the ramifications of the case in terms of the didactic assignment.

Members of the Continuation Course II group (from the classes of 1970–71 and 1971–72) have elected to continue a more intensive experience. This group meets with Continuation Course I and, additionally, meets another afternoon monthly (4 hours). This group has elected to have guest seminar leaders and has studied the following topics this year: crisis intervention; problems in drug and alcohol addiction; ethics, values, and sexuality; and Eriksen's model of personality development.

The method and content of the First Year Course have, likewise, evolved. The current format relies heavily on audiovisual techniques both for teaching and evaluation purposes. Both diagnostic and treatment techniques are presented by materials furnished by the Audio-Visual Section of this Department. Short (1–2 minute) case vignettes are presented as affect stimuli for the class members after the technique of Kagan; the purpose of this exercise is for the physicians to experience their own emotional responses to different patients; the assumption is that an emotional response may modify their helping response as a physician and that awareness and acceptance of one's emotional response enables the physician to clarify his helping response. Approximately 15 hours are spent on this exercise during the first months of the course. A typical afternoon (first 3 months) is: affect stimuli, 1 hour; audiovisual presentation and discussion of cases and treatment, 1½ hours; didactic presentation of transactional analysis, 1 to 1½ hours. During the second 3 months, patient presentations, group supervision, gestalt therapy, family and marital counseling are presented. Supervision (1 hour weekly) is ongoing for the entire 9 months. Content of the 4-hour class period for the third 3-month period is negotiable and determined by the class in consultation with the faculty.

Students

The majority of the students are practicing physicians; of these, 75 percent are general practitioners. Currently, 42 physicians, 3 ministers, 2 nurses, 1 dentist, 2 psychologists and 4 housewives are enrolled.

None of the physicians had prior postgraduate education in psychiatry. Most of them had little interest in psychiatry in medical school and realized the importance of emotional problems only after entering practice. All were motivated by an interest in enhancing their skills. During the past 2 years, the national emphasis on postgraduate education has influenced a number of physicians to take this course. There is a continuing pool of physicians in the community who are interested in this course. Several graduates (5) have gone into psychiatry; from the viewpoint of the intent of the class, these represent "failures."

Program Evaluation

Didactic evaluation is in the form of short "tests" during the year when the physicians commit themselves to diagnostic, psychodynamic and genetic formulations and treatment suggestions in reference to audiovisual presentations. Sensitivity to transactions was evaluated by the method of Kagan in one group with some success. Another type of evaluation is determining rate of admissions and return rate of patients to State mental hospitals from selected rural communities. Two communities evaluated had a lower admission and return rate than corresponding communities. The trainees contribute to the evaluation by anecdotal information from their everyday experiences.

A major impact of this program has been to enhance communication and acceptance of the medical school in the medical community. Another effect has been an increased confidence of the psychiatric community (and vice versa) in the abilities of the practicing physician to manage very ill patients.

Significant changes in the program are referred to in the methods section. The major change is the evolving concept that the physician determine his own needs for further experiences and utilize appropriate learning sessions to implement these needs.

The major strength of this program is its flexibility in terms of physicians' needs; a major weakness is that this type of instruction cannot be available for more than a few physicians each year.

Psychiatry–GP–Postgraduate Education

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MH10814 1967–1974

Objectives

The purpose of this program is to coordinate, stimulate, and foster the continuing psychiatric education of physicians in Pennsylvania in order to provide their patients with effective assistance with their emotional problems at the primary care level.

The specific objectives of the grant are: (1) to increase the participation of physicians in CEP programs; (2) to categorize the goals of the various courses in order to provide physicians with a course guide that will be useful in selecting suitable programs; (3) to coordinate the presentation of CEP programs to ensure that courses are geographically apportioned to provide continuing education in psychiatry in both the urban and the rural areas of the State, that course conflicts are reduced, and that courses are presented in deficient areas; (4) to stimulate the development of workshops, seminars, and noncourse approaches to continuing education in psychiatry; and (5) to evaluate the courses presented by the training institutions to determine the degree to which the courses achieve their objectives.

Methods and Content

A survey of the State's hospitals and professional medical organizations was conducted to determine the status of CEP training and interest in developing new CEP programs. The response to this survey provided a prospect list of hospitals and medical organizations with expressed interest in the sponsorship of CEP programs. This survey resulted in a number of new courses in areas which previously had no programs. In cooperation with the State office of mental health, the list also was provided to regional mental health/mental retardation coordinators to assist them in recruiting physicians to participate in the expanding and developing mental health/mental retardation units.

The majority of the CEP programs in the State are conducted by the medical schools and major hospitals with financial support provided by NIMH. During the last few years, many local hospitals have organized courses at the suggestion of the Steering Committee, using local psychiatrists as their teachers. These hospital-based programs are supported by tuition, drug company support, or a combination of these methods. Some hospitals recently have agreed to provide full financial support for CEP programs, and contractual arrangements are made with the training institutions. Program planning is a cooperative process to ensure consideration of the trainee's needs.

The committee provides the training organizations with the names of physicians in the proposed course area who responded to surveys, brochures, or newsletters, or who indicated some interest in CEP at continuing education booths the project sponsors at medical meetings. It also arranges for the publication of course announcements in medical journals, assists in the preparation of course brochures, and provides a mailing service for course announcements.

A CEP newsletter is published and mailed to members of the Pennsylvania Academy of Family Physicians, Pennsylvania Osteopathic Medical Association and the Pennsylvania Society of Internal Medicine. This newsletter contains case histories of the management of patients' emotional problems by nonpsychiatrist physicians, and a list of scheduled courses. Response to the newsletter has resulted in many new recruits and several new courses.

A master file of physicians (by area) who have taken CEP courses is maintained at the Committee's central office, in order to assist the training institutions in their recruiting efforts.

One of the most effective devices the Committee has found to accomplish both coordination and improvement of courses is the annual teachers' conference. These conferences are not only attended by the central course administrators and their faculties, but attract other psychiatrists who have not been involved in physician training before, and who are interested in teaching and/or organizing courses. Invitations to these conferences were mailed to all the psychiatrists and to nonpsychiatric group leaders in the State.

The professional medical organizations and voluntary health organizations are natural allies, and have cooperated wholeheartedly in the expansion of CEP training. Through these organizations, the Committee has succeeded in getting approximately 10 percent of continuing education programming in the psychiatric area and has arranged for speakers for major programs. In addition, it has arranged to have psychiatrists on panels for presentations on major health problems, such as cancer and stroke, to ensure the discussion of the emotional aspects. Through a voluntary health organization, a program on the dying patient was arranged and will be replicated in several other areas of the State. The Committee also secured a grant from the Pennsylvania Department of Health to enable the Pennsylvania Medical Society to present nine area programs for physicians on Drug Use & Abuse. Several psychiatrists will be used on the panels of these drug conferences to ensure the discussion of the emotional aspects of drug use, and the Steering Committee will provide the program's moderators.

Students

This grant does not provide for training the students, but only for coordination and promotion of training programs.

Program Evaluation

Methods include interviews with students, interviews with course administrators and discussion leaders, after course surveys and questionnaires, and observation of training programs. Program evaluation is performed by the staff of the Staunton Clinic, University of Pittsburgh. A statewide survey of CEP students is planned for the spring of 1973 to determine the impact of this 7-year grant.

The most recent survey of participants in the innovative conference for physicians and family members, "What You Always Wanted To Know About Doctoring, But Were Afraid To Ask," indicated that 76 percent of the physicians had not previously attended a CEP program.

Through presentation in and/or visitation by persons from other States, many of the project's innovative methods have been replicated in other States; i.e., newsletter, MH/MR Unit funding of courses, CEP booth at medical meetings, hospital course contracts, telephone recruiting, cooperative programs with professional and voluntary health organizations, and the annual teachers' conference.

The programs of the annual teachers' conference have been replicated by others for the past several years. The 1970 films of teachers conducting training sessions, and the 1971 films of physicians in their offices actually at work managing patients' emotional problems, have been shown at several State and National meetings, and have been replicated in other States. The 1972 conference for teachers and physicians, "What You Always Wanted To Know About Doctoring, But Were Afraid To Ask," has been replicated numerous times within the State, and will be presented at several State scientific assemblies of the AAFP. This conference has also been successfully presented as a weekly series by several training institutions.

GP Postgraduate Education

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MH08382 1964–1975

Objectives

The Physician Education Project of the Institute of the Pennsylvania Hospital has an extensive program for the education of physicians in psychiatry in the Greater Delaware Valley Area. Generally, the objectives are to improve patient care and to orient medical practitioners to the role of the emotions in their patient's illness. Some of the more specific goals are to teach medical practitioners to diagnose, treat and refer emotional problems in their practice and to improve communications and interpersonal relations skills.

Methods and Content

The decisions about structure and content of programs are made by assessing the needs of the community in which the education is being offered and ascertaining the self-perceived needs of the physicians. There is an advisory board of experts in specific fields who assist in programming. Constant monitoring and evaluation of programs also gives feedback which affects these decisions.

A number of different approaches to teaching are used in the program. Lectures and subsequent group discussion are used with a skilled moderator who facilitates the group process. Practical work sessions are used where a specific skill is being taught as in the Medical Hypnosis Course. Each small group of four students works with subjects under the supervision of a skilled medical hypnotist. In addition, the Hypnosis Course utilizes lectures, demonstrations and panel discussions.

One of the latest training methods being explored is the use of experiential learning techniques. Role playing, simulations and a variety of other sensitivity techniques are used to explore the interpersonal aspects of physicians' lives with their patients, families and colleagues.

Another teaching approach which will be explored this year is "Interpersonal Process Recall," which uses videotape playback of interviews to stimulate recall. This technique is the work of Dr. Norman Kagan at Michigan State University. A videotape of an interview is replayed to the physician, who, with the aid of a specially trained recall worker or "inquirer" examines the underlying dynamics of the physician's interaction with a patient.

For a group of family practice residents and family practitioners at Lancaster General Hospital this year, a psychiatric interview of a patient was integrated into general medical rounds with round-table discussion afterwards. This has been a very productive approach to teaching psychiatry to medical practitioners.

Some of the specific content areas are depression, suicide, mental problems, sexual problems, alcoholism, drug abuse, use of psychotropic drugs, family process, interviewing techniques, psychosomatic problems, emotional problems of children and adolescents, geriatric problems and death and dying.

Courses vary anywhere from 6 to 40 weekly sessions of 2 to 3 hours. Sensitivity sessions run 4 hours for 10 weekly sessions. The Medical Hypnosis Course runs for twenty-two 4-hour sessions for a total of 88 hours.

Students

Trainees are practicing physicians; general practitioners, internists, pediatricians, obstetricians, a few anaesthesiologists and surgeons.

Program Evaluation

Each program has an evaluation scheme which is designed at the same time the objectives of the program are identified. An instrument or procedure is developed for each educational effort. Several innovative evaluations have been developed in connection with new developments in our programs. In the experiential learning program for physicians, a trained participant-observer sat in with the group for 10 weeks and collected vignettes which illustrated how the physician's behavior with a particular patient changed as a result of insight achieved during the sessions.

Another approach to assessing learning in the programs was an evaluation instrument designed to compare attitudinal change in an experience-based group as compared with a lecture-discussion group. The results are to be published next year.

This year, evaluation of the Psychiatry on Rounds program at Lancaster General Hospital will be done by means of videotape. A series of psychiatrist-patient interviews will be videotaped. Criteria will be developed and comparisons will be made between a resident's performance at the beginning of his residency, after the psychiatric seminars (second year) and at the end of the residency.

A number of other evaluation instruments were developed for specific courses which ranged from questionnaires to measure information retention to Patient Management Problems which assess the physician's strategy in attacking a problem.

There are a number of unique aspects of the program which could be duplicated, such as the "Interpersonal Process Recall" method of teaching described above. The impact of the programs on various communities in which they were offered has been documented in progress reports. One interesting example is an educational project at Presbyterian Hospital, a community hospital in West Philadelphia. Focusing on "Caring for the Terminally Ill," the educational program was designed in conjunction with the creation of a therapeutic milieu for dying patients. The program will affect not only the care of the terminally ill patient but the necessary support which the hospital will develop for the family and staff.

One of the changes which has occurred in the program is the creation of "Sensitivity Training for Physicians," a series of ten, 4-hour intensive group experiences which utilize role playing, simulations and a variety of other techniques to explore the interpersonal aspects of physicians' lives with their patients, families and colleagues.

Another new educational project for this year is a conference for Deans and Chairmen of Departments of Medical Schools entitled, "Human Dimensions in Medical Education," to be held in March 1973. This conference will be co-sponsored by the Physician Education Project of the Institute and Dr. Carl Rogers. Designed specifically for teachers of medicine, this "human relations" seminar will focus on the interpersonal aspects of medicine. Humanistic approaches to change in medical schools will be explored.

The major strengths of the project are the constant seeking out and application of new and interesting educational approaches and educational projects for teaching psychiatry to physicians. Continuous personal monitoring and evaluation of educational projects are other strong points of the programs.

The programs have been innovative because the whole approach to continuing education in mental health has been to find new effectual methods of helping physicians deal with the emotional aspects of medical care.

Psychiatry–GP–Postgraduate Education

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MH06809 1959–1974

Background

School nurses are trained through this program in the emotional development of children and in the signs, symptoms and patterns of maldevelopment. The program is intended to help them learn to diagnose and manage or refer children with emotional maldevelopment whom they see in the course of their daily practice. More specifically, the nurses are taught skills in data collection by improving their interviewing techniques, and are helped to analyze data with a view to developing diagnostic formulations that suggest a method of case management by the nurse. In cases inappropriate for case management by the school nurse, she is helped to develop an effective method of referral to an appropriate resource.

Methods and Content

The first phase in the training program is a series of eight orientation seminars covering pregnancy, infancy, the pre-school period, the schoolage child, and the adolescent child. Emphasis is placed on the normal characteristics and tasks of each period and upon examples of deviations; specific points are illustrated by case material presented in anecdotal form or by excerpts from audio tapes. Each seminar is of 2 hours' duration and the eight seminars that make up the series are given over a 16-week period. In phases 1–3, eight school nurses make up each seminar series, and two series are held concurrently on alternate weeks.

The orientation seminars are followed by a second series of eight 2-hour seminars; in these, diagnostic formulations and case management are discussed. Participants are provided with detailed case histories of two cases 2 weeks in advance of each seminar and assigned the tasks of studying these cases and making diagnostic formulations and management plans. Each seminar is an informal discussion of the cases.

Phase three consists of a series of eight seminars of 2 hours each in which the participants have been provided with detailed outlines of semi-structured interviews of the parents separately and together and of the child. The participants first observe a staff member interviewing patients in an interview room equipped with a one-way mirror; in the later sessions the participants themselves practice doing semi-structured interviews observed by the instructor and the other participants. Following the interview, the group meets for discussion, with the main emphasis on interviewing technique but with some discussion of the content. The trainees also observe the child through a one-way mirror receiving psychologic tests while important behavioral characteristics observed during the testing are pointed out to them. The data the group has collected over a period of several weeks are then put in written case history form and the group discusses diagnostic formulations and management of the case they worked up themselves.

Six school nurses participate in phase four. A faculty member visits each nurse every 2 weeks in her school office to help her collect data on a patient who has come to her with a psychosomatic complaint. As part of the workup, psychologic testing is arranged for the patient, as is a physical examination by the school physician, and further medical investigation where appropriate. The collected data are then presented at a conference, attended by the school nurse, the school physician, the child's teacher, the school counselor, and the principal, where diagnostic formulations and case management are discussed.

Program Evaluation

Quantitative evaluation of the program has been explored, but was not considered feasible by behavioral science consultants interested in research. Evaluation is therefore qualitative, based on the opinions of the trainees, the superintendent of nurses, and the director of school medical service.

As the program is quite highly structured and the interviews semistructured and well-outlined, replication should not present great difficulties. Also, the population of potential trainees is large, as it could include all school nurses in all public school systems.

Summary

As a result of the general climate in school medical services to which this program may have made some contributions, there is much interest in freeing school physicians and school nurses from routine work such as clerical tasks, mass immunizations, mass physical examinations, etc., so that they can provide more individual attention to pupils in need of their services, and more continuity of care.

The emphasis of the effort of this continuing education project has been away from practicing pediatricians and general practitioners, who are frequently too busy to collect data on those patients whose primary difficulty is emotional. Efforts were made to work with school physicians, but it was found that their motivation was spotty, and that even where good motivation was present the nature of their jobs allowed them little opportunity to provide individual attention or continuity of care because they were so overburdened with mass immunizations and routine physical examinations. School nurses were found to be the medical personnel most likely to have personal contact with the students and the time and interest to sharpen their skills in the handling of students with emotional difficulties, particularly those who presented with psychosomatic symptoms.

Psychiatry–GP–Postgraduate Education

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MH06808 1958–1973

Background and Objectives

Staunton Clinic, a privately endowed affiliate of Western Psychiatric Institute and Clinic, Community Mental Health and Mental Retardation Center, has conducted case-centered research-cum-training seminars for physicians for the last 15 years. It has now undertaken to make available similar teaching/learning experiences for other mental health professionals and members of related disciplines.

General objectives are: to clarify and expand professional identity; assist mental health professionals develop more effective responses in their professional role to their clients; aid them in gaining a better understanding of appropriate referrals and of the mental health resources available to them and their clients and develop competency of professional staff of this unit and others to conduct continuing education seminars.

Specific objectives are to develop a wider range of understanding of the situation and needs of patients/clients and a larger body of skills in responding in a professional way to those skills. The specific objectives developed out of the Clinic's work with physicians are being used as a guide in developing similar specific objectives in the work with each discipline or group. The Clinic's experience in previous training projects demonstrates, however, that the specific way in which a professional will change his practice as a result of work in a group is unpredictable and the amount of time it takes is quite variable. A physician in an established practice may take a couple of years or more to integrate significant changes into his practice. Young practitioners just beginning to function appear to utilize at least some of their learning more rapidly. The Clinic's approach is to free professionals to use themselves in spontaneous and relevant ways consistent with their professional identity and goals. Because of this, the Clinic staff concludes that listing specific objectives limits rather than facilitates that work.

Specific objectives for the training program for group leaders are to: (1) enhance the potential leader's experience and understanding of group process; (2) expose potential leaders to information about positions, functioning and problems of professionals likely to participate in groups; and (3) evolve skills in facilitating group discussion of problems, exploration of alternatives available, and experimentation with alternatives in practice.

Methods and Content

Primary Groups—The Clinic will explore the relevance of its experience with one method of case-centered group seminars to the work of other professional groups. Content will be whatever the involved participants bring up with respect to their professional work. The staff is alert to retaining the focus on the professional role rather than personal development, but discussion of the relevant emotions of both the professional and his client are central issues. Seminars will be recommended weekly for 2 hours in units of 10 to 13 weeks.

Staff Group—The primary mode of training potential consultants will be: (1) assignment of competent professionals as co-leaders of ongoing groups and (2) inviting their participation in the weekly Staff Seminar on Group Processes in Training. One such Staff Seminar is in process, and if the group gets larger, it may be divided into two or more, each under the leadership of one of the senior consultants. The staff group develops its own agenda, as problems relating to recruitment, starting, conducting and ending groups are discussed. It will ordinarily meet weekly for 1½ hours.

Students

As the Clinic's experience has grown, so has its awareness of the relevance of this method of working with any persons dealing with human services. Its current view is that it would make known its approach and be prepared to respond to any group, unidisciplinary or multi-disciplinary, which views itself as prepared to work on a better understanding of the functioning of the participants in their professional roles in case-centered seminars.

Program Evaluation

The Clinic has 10 years' experience in outcome evaluation, and copies of its reports are available upon request. The evaluation has comprised observation of seminars and of physicians in their offices, and the use of semantic differential. In the absence of substantial funds for evaluative effort, it would appear that outcome evaluation will be largely limited to instrumental devices such as the semantic differential—perhaps eventually a battery of instruments.

The Clinic does have some staff trained in continuing observation of the work with a training group. They are developing sophisticated means of reporting this. This whole body of information would be available and possible for replication by other groups. As for program evaluation in the wider sense, with study of need in the new target population, etc., that requires development as the Clinic shifts its focus.

As for impact of the program, an interesting dilemma exists. The physician's program has had a low profile with advertisements going only to the target population, with resulting limited response. On the other hand, and surely partly because of skills learned in programs, staff participants have become prominent in health planning activity in the community at large (Allegheny County), in consultation and education activity in another mental health center and in other educational programs and educational research. A broader based program designed for a population already interested in mental health work might have a different kind of impact.

Principal innovations have to do with ongoing programs to enhance and broaden skills of existing workers in the field.

Psychiatry–GP–Postgraduate Education

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MH08591 1964–1974

Objectives

The general objectives of this training program are to enable pediatricians and general practitioners to understand psychological aspects of their child patients' reactions to illness, accident, injury and various aspects of growth and development. The child patients' caretakers, i.e., the parents or parent surrogates, are also included in these objectives.

Specifically, the trainee target groups have been the pediatricians, school physicians, family physicians, their nurses and office personnel and all other related disciplines such as social workers, teachers, child-care workers, house parents, etc. The aim has been to bring about specific changes in their behavior with their patients based on an understanding of the dynamics of child growth and development, e.g., modification of routines in office practice and/or in hospital care of the child based on knowledge gained in the continuing education efforts.

Methods and Content

Since 1953, the Center has organized and presented an annual institute in child psychiatry for the target groups mentioned above. In the first 4–5 years these lasted 1½ days over a weekend. Since then, they have been limited to 1 day, 9:00 a.m.–4:30 p.m. The decision to change from the 1½ day format to a 1-day program resulted from a review and critique of the experience up to that point. The decisionmaking group had always included representatives of the consumers (the target groups mentioned earlier). In most years there was a formal relation with the Southern California Chapter of the Academy of Pediatrics and one or two of their members were active in the planning, developing and implementing of the programs. Several also served as presenters and/or resource persons on the panels.

The format of the institute was to have one or two main presentations from the field of child psychiatry, psychoanalysis, or psychology on the theme chosen for the day. This was followed by one or two formal discussants chosen from the ranks of child psychiatry, psychoanalysis, pediatrics, psychology, social work or general medicine. Following the main presentation and discussion, the audience was split up into small groups of 10–12 each with a member of the staff as group leader. Following a 2-hour discussion group, the participants reconvened for a report and summarizing session of the groups' deliberat[illegible]

In addition to [illegible] efforts described for the institute progra[illegible] hour seminars of 6, 8 and 10 weeks' du[illegible]on were offered in both fall and spring. The content of the seminar was determined in joint conferences with potential registrants at all times.

Specific content areas have ranged widely over the entire spectrum of childhood growth and development, both from a normal as well as a psychopathological point of view. The following are some of the themes and topics covered since 1953: (1) Learning Disorders; (2) Psychosomatic Problems in Childhood; (3) Sex Education for Childhood and Adolescence; (4) Maternal Deprivations; (5) Psychosis of Childhood; (6) Problems of the First Years of Life; (7) The Pediatrician's Role in Head Start; (8) The Pediatrician's Role in Prevention and Treatment of Emotional Disturbances; (9) The Hyperactive

Child; (10) Mother-Infant Relationships; (11) Normal and Pathological Conflicts in Childhood and Adolescence; (12) Childhood Emotional Disorders: Prevention and Management; (13) The Impact of Physical Illness on Parent-Child Relationships; (14) Current Theories of Special Education; (15) Anesthesia and Surgery: Emotional Factors in the Preparation of Young Patients and Their Parents; and (16) An Approach to Common Developmental Problems in the Early Years.

Students

The trainees or registrants were from the following disciplines: (1) practicing pediatricians, primarily from private practice. There were some from governmental posts, community clinics or medical school faculties as well; (2) pediatric and psychiatric residents from nearby residency programs; (3) medical students, usually from third or fourth year; (4) school physicians from all nearby school districts; (5) general practitioners and family physicians; (6) occasional medical specialty such as anesthesiology, surgery, dermatology, gynecology, internal medicine, neurology, orthopedics, psychiatrists and child psychiatrists; (7) medical and psychiatric social workers; (8) clinical psychologists; (9) nurses; (10) early childhood educators; (11) day care center workers; and (12) attorneys.

In terms of numbers within each category, it is noted with interest that in the first 5–6 years of developing and offering such programs, the registrants were 65–75 percent pediatricians and family physicians. The next highest group (5–10 percent) were pediatric and psychiatric residents plus medical students. Social workers and nurses were 3–5 percent and the balance was made up of all others.

In the middle 5-year period, a gradual decrease in the number of pediatricians and family physicians to a 40 to 50 percent figure was noticed. The registrations from the social workers, day care center workers and clinical psychologists increased to 25 to 30 percent. A new discipline, the teacher from public, parochial and private schools, began to show on the registration and soon reached 20 to 25 percent of the total.

In the last 5-year period of offering these institutes and seminars, the program has found a continuing decline of the pediatric and general practitioner registration to a 20 to 25 percent level. The increases in registration have come from the nursery school, day care center and early childhood field, as well as from the social workers and psychologists. Since the community now has four or five other institutions offering continuing education for the pediatric and general practitioner, it is felt that there is a surplus of such offerings. Information regarding registration in these other programs reveals that all have suffered a decline in registration and attendance by the medical disciplines.

Program Evaluation

Program evaluation has not been carried out in any highly structured method. It has consisted of a one-page questionnaire given to each registrant who is then encouraged to furnish a critique of the experience of the institute and/or seminar and this data is reviewed by the planning and organizing committee and observations are made in regard to the plans for the following year. The registrants are encouraged to submit ideas for themes of future institutes and seminars and approximately 60 percent of the content was developed from such requests or suggestions.

There is good potential for replicating the programs at local, regional or national levels. It depends only on reaching an agreement as to theme and then finding the most appropriate individuals to present the material and/or to lead the discussion.

The community, institutional and organizational impacts of the center's efforts are best reflected in the quality and nature of care being given to infants and young children. Comments given to the program by the pediatricians, general practitioners and the families that they serve indicate a change in the nature of their understanding as well as their behavior with child patients.

The major strengths are those of offering specific topics and presentations related to a theme; thus, they are content oriented, have an informal didactic aspect, but also draw and rely heavily on the input of the registrants' practical experiences. With this blend, concepts come alive within the group so that they then are better able to understand and to incorporate these concepts into their practise.

The weaknesses stem from the limited availability of participants who could carry roles such as instructors, seminar leaders, group or workshop discussion leaders, and discussants. At times, the shortage of funds available to obtain the services of these individuals has been the key obstacle or weakness. At other times the center has not been able to find enough personnel to carry out the needed tasks.

Psychiatry–GP–Postgraduate Education

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MH08997 1965–1975

Objectives

A program of postgraduate psychiatric education for nonpsychiatric physicians has been presented for the past 8 to 10 years by the Department of Neurology and Psychiatry of the St. Louis University School of Medicine. The major objectives of this program were, and continue to be, to develop in physicians: (1) increased understanding of the nature and role of emotional factors in illness, (2) an increased sensitivity to an acceptance of these factors, and (3) an increased skill in dealing with emotional factors of their patients. The ultimate goal of the entire program is to improve the quality of medical care that physicians provide for their patients.

The accurate and positive diagnosis of mental illness and emotional disorders is the responsibility as well as the goal of all medical practitioners. The management of mental illness is not the exclusive responsibility of psychiatry; indeed, there never will be enough qualified psychiatrists available to serve the many persons who need such help. In addition, the influence of emotional factors contributes to the causation, continuation and complication of physical disorders and most patients see their general physician for all problems and he should be able to treat them, or recognize which to refer and how and to whom.

Methods and Content

Training methods used in presenting the program have included the following: (1) audiovisual materials; (2) clinical conferences; (3) enrollee observing procedures; (4) enrollee performing procedures; (5) lectures; (6) open questions; (7) panels; (8) patient demonstrations; (9) seminars; (10) closed-circuit television; and (11) individual consultations.

Specific content areas have included: (1) general psychiatric problems in medical practice; (2) comprehensive medical care and the doctor-patient relationship; (3) problems in sex in marriage; (4) psychiatric problems in the pediatricians' practice; (5) psychiatric problems in the adolescent; (6) emotional problems of aging; (7) emotional problems of the hospitalized medical and surgical patient; (8) interview demonstrations and practices; (9) psychological factors in industrial medicine; (10) psychiatric diagnostic methods; (11) psychotherapy supervision; (12) family therapy; (13) diagnosis and treatment of health problems in poverty areas; and, on special arrangements and at various times; (14) psychiatric problems seminar.

Emphasis has been placed on offering a continuing learning experience tailored to fit the needs of the individual physician, involving his own capacities and limitations as well as his concerns and interests. Most courses consist of 2-hour weekly sessions for 6 or 8 weeks. A few courses run throughout the year.

Students

For the first several years, trainees of the program were physicians, M.D.'s and D.O.'s, practicing medicine from all the various specialties. About 30 percent of the participants were family practitioners, probably a similar percentage of pediatricians, and the rest were divided among the other specialties. At the time of the writing of this review, this is the first year in which other disciplines have been included; e.g., psychiatric residents, psychologists and psychology interns, social workers and social work students, and religious workers.

Program Evaluation

Courses were evaluated by having participants fill out a rather simple questionnaire. In addition, the program director discussed the reaction and feeling of the trainees to the courses and tried to get some impression to what extent the trainees were using any new attitudes and knowledge developed in the seminars in changing the way they related to their patients and conducted their practice. Observations were made of those participants who continued to take courses year after year to determine if they seemed to be presenting material about their patients differently, if they appeared to demonstrate an increased understanding of their own feelings and reactions in interacting with their patients, and if they seemed to show an increased ability to empathize with the emotional factors that were present in the patients they saw in their daily practice.

One of the most important facts that was learned in this program, and that has been demonstrated and experienced by other faculties of continuing education in psychiatry throughout the country, is that benefit derives only to those participants who are dedicated to continuing study and application of mental health and behavior principles over a protracted period of time, probably a minimum of 2 years. This obviously does not have to be a full-time type of training and consists of the type of programs developed on a continuing basis in which the individual participant devotes 2 to 4 hours a week to course work of a participating nature as well as reading and other study and the constant application of what he has learned in his daily practice.

These seminars have been given over a period of 8 to 10 years and seem to have reached the current number of physicians that are interested in this type of continuing medical education. As a consequence, during the last 2 years, instead of trying to schedule several courses as had been done in the past, one or two popular or new courses have been scheduled, with the teaching activities dependent upon the interest and initiative of a group of physicians getting together, deciding when, where, what, and by what method they would want to participate in a learning experience that would fall under the stated objectives of this program.

A weakness of this program is the excessive amount of time and effort that had to go into recruiting participants and publicizing the program and trying to stimulate physicians' interest in the whole subject of continuing medical education and psychiatric education in particular.

The strength of the program was felt to be its continuity—providing an opportunity for physicians to become continuously involved in a learning experience of greater breadth and depth and intensity as their interest and capability would permit. Another strength of the program was the cooperative working together of the University with other mental health and health agencies of the community, including the various specialty societies, the Psychoanalytic Foundation of St. Louis, other community hospitals, the regional medical program and particularly the American Academy of Family Practice. The program's innovative approach of offering the teaching of family therapy to practitioners along with other mental health disciplines has been well received and appears to be filling a long felt need.

Psychiatry–GP–Postgraduate Education

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MH11124 1967–1974

Background and Objectives

Ongoing postgraduate psychiatry seminars and other psychiatric learning experiences for nonpsychiatrist physicians have been well received for a number of years throughout the State of South Carolina. Course content includes appropriate involvement and awareness by the primary physician of methods of prevention and diagnosis, timing of referrals, and management of the psychiatric aspects of medical practice. The demands and needs of the primary physician as well as his level of prior, present and anticipated future involvement assist in the determination of the type of learning experience which may be extended by the training program.

The general objective of the program is to present to primary physicians relevant utilizable, psycho-, sociophysiological, educational endeavors with pertinent new techniques which may assist them in the comprehensive management of patients, family, hospital staff, groups and community agencies. The program is directed primarily to pediatricians and family practitioners delivering health care services in various cities throughout this State and Charlotte, North Carolina, and provides a variety of learning experiences aimed at enhancing their awareness and appropriate techniques in identifying, counseling, making appropriate referrals or utilization of available resources.

Methods and Content

Seminars, audiovisual endeavors, supervised interviews, and appropriate printed materials constitute the methodology of this program.

This year the main effort has been made in the direction of house officers and nursing personnel. The pediatric and family practice residents and interns have met jointly on a regular basis every 6 to 8 weeks to discuss psychological development and so-called comprehensive pediatrics. This has been supplemented by rounds on the wards in which the effort was directed toward this aspect of pediatrics. Project staff report that it has been a particularly rewarding experience to deal with the family practice residents who seem to recognize the importance of this subject. In addition, the house officers have rotated through the project office to receive indoctrination on child care as well as the psychological aspects of acute and chronic illnesses.

Course hours for training activities vary from 2-hour case conferences in hospitals with the primary physician and house staff, to 20 hours a year ongoing case presentation-seminar type training activities.

Students

The continuing education program has involved primarily pediatricians and family practitioners and, secondarily, other specialties as well as invited nurses, house staff, mental health associates, administrators and teachers.

Program Evaluation

During the past year, conversations were held with primary physicians throughout the State relative to what their felt needs were as it pertains to psychiatry, as well as validating the quantity and quality of the emotional needs of the patients whom they were seeing. In Charleston and Greenville, periodic conferences were held with pediatricians.

The success of this ongoing postgraduate educational endeavor has encouraged the South Carolina Department of Mental Health to secure a full-time director of continuing education for the nonpsychiatrist physician.

Postgraduate Psychiatry for Nonpsychiatrist Physicians

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MH07108 1959–1974

Objectives

The general objectives of the program are to bring the latest developments in psychiatric techniques to the participants, to refresh them about techniques that they do not use frequently, to improve their general therapeutic skills, and to inform the participants about the changing role demands in psychiatry based on public health and community mental health models. Included in this general approach is strong interdisciplinary emphasis both in faculty, participants and content.

Methods and Content

The training methods used in the program vary according to the specific goals of a particular course. These goals are based on the interdisciplinary staff's interpretation of what is needed by mental health professionals and by what the mental health professionals suggest in surveys and in post-course evaluations. This year the program is developing training programs in conjunction with service delivery agencies as well as with individual professionals. Formats and teaching methodologies include day-long to week-long seminars with formal lectures, videotapes, discussions and case demonstrations.

Courses presented in the 1971–72 year were "Intensive Review of Psychiatry and Neurology" (primarily for psychiatrists preparing for the specialty boards but also including boarded psychiatrists who desired a refresher course) conducted in twelve weekly 2-hour sessions, a weekend of patient demonstrations and actual diagnostic examinations and a mock oral examination; a weekend seminar entitled "Neurological Problems in Psychiatric Practice"; a day-long seminar entitled "The Future of Psychiatric Practice"; an interdisciplinary weekend seminar called "Community Mental Health: Models and Methods" and a week-long seminar entitled "Innovations in Psychotherapy." In the 1972–73 year, a 1-day interdisciplinary seminar was held concerning the application of the "Problem Oriented Record Keeping System" to mental illness.

Students

Course enrollment in the 1971–72 grant year has more than quadrupled and enrollee hours have increased ten-fold since the beginning of the continuing education grant 5 years ago. This year, 410 enrollees received 8,967 hours of instruction.

While the grant is primarily for the continuing education of psychiatrists, the Division did make an effort to implement an interdisciplinary seminar concerned with community mental health and one concerned with psychotherapy. The effort was well-rewarded, in that 29 nurses, 18 social workers, 12 psychologists, seven teachers and 15 persons from other disciplines joined the 194 psychiatrists at these two seminars. The first program of the 1972–73 year was also interdisciplinary. Joining the 41 psychiatrists at the problem-oriented record system seminar were seven nurses, three psychologists, three social workers, five administrators and four persons from other disciplines. The planned agency-oriented, continuing education programs will be interdisciplinary also.

Over 71 percent of the psychiatrists participating in the psychotherapy seminars of the last 2 years received their medical degrees after 1951. Over 76 percent had been in psychiatric practice for less than 15 years. Approximately 60 percent of the respondents were not board certified at the time of the seminar. Slightly over 75 percent of the respondents spend the majority of their time in direct patient care.

The target groups change as the goals of the program change. For example, in the initial years of the grant, the goal was to reach the individual psychiatrist. In the last 2 years, many of the programs have had the various mental health professionals as the target group. In the coming year, some of the programs are going to be agency oriented; that is, they are going to be planned and conducted in conjunction with and for a particular agency on a multidisciplinary level. This will allow the training to be much more directly related to improvement of services.

Program Evaluation

Although no evaluation funds have been awarded through the Continuing Education Training Grant, program evaluation started at the inception of the grant 5 years ago. It has been continued and expanded with difficulty throughout the life of the grant. Specific evaluations focus on the satisfaction of the participants, the perceived learning of the participants, actual performance on written examinations, and actual changes in behavior. All these approaches are not used for all courses. Much of the information is used to improve future courses.

In all the courses, over 90 percent of the respondents indicated the programs were either "excellent" or "good." Perceived learning, in general, also has been high. In the 71–72 year, the enrollees reported that over 38 percent of their patients would benefit from their participation in the course in terms of technical skills, and over 42 percent in terms of the doctor/patient relationship.

Systematic data from the Intensive Review course indicated that the participants increased their substantive knowledge, improved their clinical interviewing skills and passed the Boards in significantly greater proportion than the national average of psychiatry Board candidates.

In order to make the program's experiences, evaluations and course methodologies available to others, the Division instituted a Technical Report Series which has been widely distributed. The Series contains 21 papers concerned with medical and mental health education and an additional 19 papers in allied interest areas.

Continuing Education Nonpsychiatric Physicians

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MH11961 1969–1973

Background and Objectives

This project, conducted by the Mental Health Program of the Southern Regional Education Board, grew out of a need of the various programs concerned with continuing education for family physicians in management of the emotional problems of their patients in 14 States of the South to develop new approaches for stimulating and improving their programs. Some of these programs were being carried out by departments of psychiatry in medical schools, others by State departments of mental health, others by mental health centers or even private practicing psychiatrists. Many programs were experiencing problems in getting physicians to attend, or in evaluating programs. The project was conceived to provide a forum and mechanisms to develop guidelines for solving some of these problems and to enhance the competence of the planners and teachers of these programs.

The objectives were (1) to produce simple guidelines that might be helpful to persons undertaking such programs, (2) to enhance the competencies of the planners and teachers of these programs to be more effective, and (3) to explore and develop guidelines for planning and conducting continuing education programs for physicians with unique aspects to their practices (i.e., rural practitioners, pediatric practitioners, physicians with largely geriatric practices, and black physicians.) It was expected that ultimately achieving these objectives would provide more and better quality continuing education programs and more family physicians who do a better job in managing emotional problems of their patients.

Methods and Content

The project utilized these major methods:

1. Publication and distribution of "Physicians' Digest for Continuing Education in Psychiatric Education Programs," a brief periodic four-page publication to pull together in synopsis form the issues and guidelines for some aspect of planning or teaching such programs (i.e., assessing needs, planning and arranging, instruction, and evaluation). Since most persons conducting continuing education programs are busy with clinical or administrative duties, they do not have time to research all of the literature on these subjects and such a synopsis is an excellent facilitator.

2. An annual 3–4 day conference to bring together the planners and teachers from the 14 States of the South for problem solving seminar-like discussions, for explorations of new technology (i.e., gaming simulations and videotape playbacks) in continuing education for physicians, for exchange of experiences, and for learning about resource persons, materials, etc., which they might use in their own programs.

3. Small workshops for concerned family physicians and psychiatrists to explore continuing education needs, problems and promising approaches for those physicians who have unique aspects to their practices (i.e., rural practice, geriatrics, pediatrics, black physicians). The findings of each workshop to be published in an issue of "Physicians' Digest."

4. Consultation to individual State or local groups on any aspects of their programs.

Students

There were no students of this project in the traditional sense. The participants were mainly physicians (both psychiatrists and family physicians) from throughout the region who expressed an interest and paid their own way to the conferences (except the workshops). The mailing list for "Physicians' Digest" included all departments of psychiatry, all State departments of mental health, all district branches of the American Psychological Association, all Continuing Education Divisions of Medical Schools, all Regional Medical Programs, all State Academies of General Practice, all mental health chairmen of State medical societies and directors of all community mental health centers in the South. In addition, many physicians are on the mailing list as individuals.

Some were from mental health centers, some from family practice groups or from departments of family medicine or continuing education departments of medical schools, some were from departments of psychiatry or State mental health departments. A few participants were psychologists, social workers or nurses.

Program Evaluation

The program is being evaluated at several levels. The product of the project, *Physicians' Digest for Continuing Education*, has published and distributed 15 issues. A number of copies have been distributed beyond the basic mailing list, in response to requests, many of which are from States outside of the South. The project has received letters commenting on how "Physicians' Digest" has been useful.

Evaluation reports have been received from persons who have participated in the annual conferences. The project plans to repeat a survey of continuing education programs that was done at the beginning of the program. Initial results showed such spotty response that the project is unsure of the value of this as an evaluation effort. It plans to also survey for ways in which people feel the project has helped them.

It is difficult to determine the impact of the program. However, a few States (Alabama, Georgia, North Carolina) have increased the number of continuing education programs for physicians. Many programs have shifted from a focus on psychiatry to a focus on the emotional problems of family practice. There is a definite trend away from formal lectures to seminar discussions, case presentations, experiential techniques such as simulations, videotape playbacks, etc. Most programs have a much greater focus on the value and attitude aspects of continuing education for physicians rather than just the traditional focus on knowledge or possibly on skills.

The major strength of the program comes from the materials which were produced. These are being used by persons who were not able to attend the conference, and by persons involved in other areas of continuing education for other professions and in staff development programs within State mental health agencies. Another strength has been the shift of focus of continuing education programs from lectures in psychiatry to more experiential learning techniques dealing with value and attitude aspects of the everyday emotional problems of patients in family practice.

Psychiatry–GP–Postgraduate Education

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MH07132 1959–1973

Objectives

This course is designed for the physician in practice seeking assistance in the management of patients suffering with emotional disorders. The training objectives are to provide the nonpsychiatrically trained physician with the opportunity to become familiar with: (1) techniques of the psychiatric interview, (2) basic dynamics underlying the behavior of the patient and his family, (3) effective management of a larger proportion of patients with emotional problems thus reducing the number of referrals, (4) ways in which assistance in the approach to and management of patients suffering from severe emotional disorders may be obtained, and (5) ways of accepting a greater share of the responsibility for the prevention of mental illness.

Methods and Content

Training methods are primarily those emphasizing the discussion of cases from the practices of physicians, illustrations from experiences of the instructors, demonstrations of interview techniques, and selective utilization of a wide range of community resources. Relevant contemporary and classical literature selected by the instructors and trainees is discussed. The proper use of allied and paramedical disciplines as an aid to the physician, and improved health care delivery are also discussed.

The course consists of two semesters of 28 hours each, making a total of 56 hours. The class meets once a week for 2 hours, and starts in September and ends in April.

Students

Trainees are physicians currently in family practice. They have received little if any formal postdoctoral training in psychiatry. The enrollment is limited to ten in order that each physician receive as much individualized instruction as possible.

Approximately 420 physicians are engaged in family practice. These physicians are all within a 1-hour driving distance of The Texas Medical Center where the course is taught.

Program Evaluation

The method used for program evaluation has been developed by Dr. Crank, the instructor-in-charge. He uses the following criteria: (1) degree of personal psychiatric insight in general medicine and psychiatry, (2) degree of group participation to clarifying existing concepts and techniques, and (3) degree of progress in awareness of psychological factors in general during course of training. The physicians are ranked three times each semester. Letter grades ranging from A (highest) to D (lowest) are assigned.

This program may be replicated at the local level but, because of the uniqueness of the instructors and the physicians and of their practices, regional or national replication would be difficult.

During the 14 years this grant has been in existence, many nonpsychiatrically trained physicians have been able to broaden the scope of their practice to include patients who needed basic psychiatric counseling, know under what circumstances referrals are necessary, and to make the appropriate referral. In one particular instance, the services of a psychiatrist were brought to a low income, black neighborhood of Houston.

The major strengths of this program are in providing the nonpsychiatrically oriented physician with sufficient training to increase his effectiveness, confidence, and competence in working with and/or referring patients with mild emotional problems. The weaknesses of this program are that only a limited number of physicians are reached and that many repeat the course. Many physicians are in family practice or are in specialty areas and could profit from this program. Although they receive an announcement of this course, only a limited number of physicians register. The latest techniques using videotape interview and playback have seldom been used and could provide a beneficial learning experience.

Psychiatry–GP–Postgraduate Education

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MH07296 1961–1973

Objectives

The Department of Psychiatry, University of Texas Health Science Center at Dallas, serves as the teaching-training hub for a well-coordinated number of mental health institutions within the area. As such, the primary educational objectives of the program are to produce competent graduate mental health professionals and to add the dimension of psychiatric knowledge to the curriculum of undergraduate medical students and to the experience of physicians in general or specialized practice. In conjunction with those goals are efforts to provide maximal care for the public patients within the teaching hospitals and to provide expanded knowledge (principally through this specific program) about psychiatric care throughout the medical community, to upgrade the quality of service available to all patients in the area.

The major goal of the NIMH Postgraduate GP Program has been to introduce the physician in nonpsychiatric practice to the teaching forum with the expectation that he may return to his community with the ability to determine which patient or patient-family problems may warrant immediate referral to a psychiatric care center; the ability to recognize the early stages of family or individual psychopathology and to intervene either directly or through referral; and the knowledge and experience which can allow him to assume leadership within his community on mental health issues. A second but equally important goal has been to increase awareness about mental health areawide, through seminars sponsored by local medical associations in outlying locations. Psychiatry staff can thus reach physicians who are unable to enroll in the program as a whole.

Methods and Content

The methods followed are essentially the following: (1) didactic lectures—to teach factual material necessary for making psychiatric diagnoses; (2) patient interviews, either live or video-taped, followed by informal small group sessions—to convey the more subtle aspects of the doctor-patient relationship; and (3) group or individual supervision involving trainees in the actual process of psychotherapy.

For this program year, the curriculum will include one time block with particular emphasis on "Child and Adolescent Psychiatric Problems and Family Interaction" which will cover eight sessions—one per week, 2 hours per session. Six-session courses to be offered (one 2-hour session per week) will emphasize the following topics: "A Comprehensive Review of Psychiatry" (a historical and definitive overview of the field), "Office Management of Common Psychiatric Problems" (patient interviews or tapes combined with discussion to convey interviewing, diagnostic, and treatment techniques for specific types of disorders) and, "Group Supervision, Short-Term, and Supportive Psychotherapy" (case presentations by trainees demonstrating supportive psychotherapeutic skills under close supervision). In addition, all courses and seminars will place more emphasis on such broad community problems as drug abuse, violence, and poverty.

Program Evaluation

Evaluation has been an ongoing part of the planning, monitoring and evaluation process under the direction of the Department Chairman. Prepost test and trainee followup interview techniques have been used, as well as individual trainee evaluations provided by staff at the completion of courses or seminars.

Basic ingredients necessary for replication of this program also have been strengthened by the program. Essential are the interfacing of community mental health services and the broad cooperation among medical professionals who are found in this area and the mental health professionals willing to spend time necessary to increase quality of mental health care in their areas. Throughout the 10 years of the program there has been a marked improvement in overall relationships between psychiatry and other fields of medical endeavor indicated by a vast rise in patient referrals as well as continuing requests for more educational materials and courses by nonpsychiatric physicians and local medical societies. The changes in the program have been reflective of the broadening acceptance of the psychiatric program in specific and of community mental health in general, within the medical community. The Department has been able to offer more programs of a specific nature (such as the 1-day symposium on "Troubled Youth" which drew nearly 1250 persons) because of this increased acceptance and awareness. Trainees within courses have also been able to move more rapidly from general information to diagnostic and treatment techniques, so training in specific skills has been accelerated.

The major weakness of the program has been the inability of the limited staff to follow the progress of all trainees once they leave courses to resume their practices. Such information would be valuable for evaluation. The major strength of the program, as noted above, has been the expansion of psychiatric knowledge, resulting in more quality and quantity of mental health care readily available to patients. A second bonus has been an increased cooperative spirit among medical practitioners in the community toward meeting the heavy challenges of providing adequate mental health care.

Psychiatry–GP–Postgraduate Education

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MH07153 1960–1973

Objectives

This seminar program undertakes to improve the skills of family physicians and other medical and mental health personnel in understanding delivery of mental health care and services. It is designed to enhance their judgment and ability in diagnosis, treatment and referral of patients with emotional disorders through case presentations of psychosis, psychoneurosis, psychophysiologic and personality disorders, and methods of therapy applicable to office and hospital practice. Emphasis is placed on community outpatient services and psychophysiologic problems as they relate to drug addiction and alcoholism, as well as the impact of social and cultural infiuences as causative factors, and methods of correction. Representatives of high priority programs, i.e., poverty, children and youth and community mental health centers participate in the planning and presentation. Instructors are representatives of the Jefferson Medical College.

Specific objectives of the program are to enhance the knowledge and teaching abilities of faculty in the Family Practice Program, to encourage the interest of residents, interns and medical students in future mental health planning and delivery of health care, and to increase the knowledge of psychiatric nurses and aides regarding mental health principles, the delivery of mental health care, and the utilization of community resources.

Methods and Content

The program is designed to provide a convenient opportunity for the physician to review the broad categories of psychiatric illnesses in order to increase his knowledge in this area. Emphasis is placed on sharpening the physician's diagnostic abilities so he can more easily identify patients who can best be treated by a psychiatrist and those whom he might benefit himself. Various techniques and methods of therapy are presented, emphasizing those useful to the family physician.

In addition, the student is apprised of current directions of psychiatric practice and research, community involvement, the community mental health programs and other high priority programs; children and youth, alcoholism, drug addiction and regional health programs.

Several methods are used to present program topics in the ten 2-hour weekly seminars, taking into account that individuals learn better in different ways. The sessions begin with a short didactic presentation, followed by case presentation, demonstration, discussion, films, tape recordings, audiovisuals, or closed circuit T.V. presentations. Students frequently choose to present problem cases or subjects of their own, such as "Depression and Suicide," "Addiction, Drugs and Alcohol," "The Role of the Family Physician in Medical Education—Interns and Residents," "Medical-Social Problems, Their Understanding and Treatment," "The Psychotherapies," "Psychopharmacological Mechanisms," "Geriatric Psychiatry," "Sexual Problems Encountered in Office Practice," "Psychiatric Problems Encountered in Family Practice From the Viewpoint of a Family Physician—An Overall View," and "Management of the Disturbed Child with Reference to Family Intervention."

Students

The eight students currently enrolled in the course include five family physicians with related interests in practice, teaching and industrial medicine, one Ph.D. clinical psychologist, and one general practitioner. Other personnel such as residents, interns, nurses and mental health workers attend certain sessions, although they are not formally enrolled. Their attendance is determined by the nature of the topic being presented.

Program Evaluation

The program is analyzed and evaluated each year by direct inquiry and questionnaire. Generally, the programs have been received most favorably by the students as evidenced by the questionnaire and the high percentage who have repeated the seminars each year.

A sample of the questionnaire which was distributed to each student last year is as follows:

1) Would you like the seminars to continue? If yes, why?
2) What day and hour would you choose for these seminars? What season of year?
3) Suggest changes you would like in the program.
4) List at least five subjects for seminars. Ten would be preferred.
5) In what ways have the seminars changed:
    a) your opinion?
    b) your method of patient management?
    c) your knowledge of community resources and participation in social programs?
    d) your knowledge and treatment of drug addiction and alcoholism?

The uniqueness of the program and its value in manpower, recruitment, education and delivery of health care, comes from combining the resources of a medical college, community mental health center and a university hospital.

The institutional impact of the project is apparent in strengthening the coordinating efforts of a multifaceted program. Evaluation of community impact is an integral part of the project.

Psychiatry–GP–Postgraduate Education

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Objectives

The influx of new multidisciplinary community mental health services for the care of the mentally ill in this geographic area has created a great need for innovative programs designed to teach contemporary techniques and skills for the solution of local individual and societal community mental health problems. As a result, this project's efforts in the past 2 years have shifted from an emphasis on the psychiatric education of the nonpsychiatrist physician to the multidisciplinary behavioral education of any active or potential members of the mental health manpower pool in the six-State geographic area of Alaska, Idaho, Montana, Nevada, Utah and Wyoming. The project has developed a dynamic program responsive to community needs determined both by community consultations and supervision by an Advisory Committee of individuals responsible for the management of the mental health facilities in this area. This program integrates the resources of this project with the faculty of the Department of Psychiatry of the University of Utah Medical School to meet the continuing educational needs of the existing mental health facilities and the medical profession in the Intermountain West. The educational process is devoted to dissemination of diagnostic and therapeutic techniques and skills applied to community mental health management of a variety of current individual and social problems.

Specific objectives are: (1) to increase knowledge and skills related to community care of the mentally ill, integration of social agencies, drug abuse, alcoholism, minority issues, sex education, child development and education, management of school problems, humanized law enforcement, whole patient medical and surgical care, and many others; (2) to improve child care in the areas of family, school, and mental health services; (3) to increase mental health expertise, including crisis management, for the first lines of defense, including police, teachers, ambulance drivers, park rangers, parents, etc.; (4) to provide inservice training in diagnostic and therapeutic skills for professional, paraprofessional and nonprofessional mental health workers; (5) to provide community consultation and subsequent continuing education programs for rural areas in the Intermountain West; and (6) to provide mental health training, including hypnosis, for nonpsychiatrist physicians.

Methods and Content

The teaching faculty are primarily members of the academic staff of the Department of Psychiatry in the University of Utah Medical School, plus a few selected professional mental health workers in the field. They teach by means of lectures, seminars, workshops and individual and community consultations.

Current mental health subjects taught by the faculty include: (1) psychiatric syndromes on behavior model (SAID), (2) psychiatric diagnosis and treatment, (3) behavior assessment and modification, (4) psychiatric liaison with other hospital services, (5) child psychiatry, (6) behavior modification in school setting, (7) psychotherapies, (8) whole patient medical and surgical care, (9) humanistic management of deviant behavior, (10) drug abuse, (11) alcoholism, (12) minority and poverty issues, (13) rural mental health services organization and development, and (14) principles of community action for improved mental health services. Course design is individualized to fit consumer needs.

Students

The student population includes all active and potential mental health workers in the geographic area. The multidisciplinary approach combined with individualized teaching yields a highly unpredictable estimate of the number and character of trainees in the program. Potential trainees in the six-State area include 3,121 physicians, 132 psychiatrists, 346 psychologists, 1,500 social workers, approximately 47,000 school personnel, 5,800 law enforcement officers, 26,500 nurses, and an undetermined number of personnel in social agencies, e.g., welfare, family service, rehabilitation, and children's services.

Program Evaluation

Programs are evaluated at three levels: (1) instrumental evaluation of teaching methods by the students, (2) quiz evaluation of the student's learning acquired in the teaching activity, and (3) evaluation of the student's performance when he returns to his professional environment.

Evaluations are gradually shaping the didactic presentations (e.g., less emphasis on lectures and more on verbal participation by the students). Level 3 evaluations are extremely difficult and were the topic of a recent Western Interstate Commission on Higher Education conference in San Francisco. The program is considering contracting some of this type of evaluation with professional evaluators.

The impact of this program in the six-State catchment area has been substantial. It involves such diverse results as the establishment of community mental health centers in Idaho and Wyoming; ongoing continuing education community workshops in Nevada (multidisciplinary); statewide drug and alcohol workshops (multidisciplinary) in Alaska; an annual family practice refresher course for the Western states (and others) held in Park City, Utah; and hundreds of other lectures, seminars, and workshops throughout the Intermountain West. The most recent and significant change in the program's format has occurred with the student population. The program has evolved from a project specifically concerned with postgraduate psychiatric education of the GP physician to a multidisciplinary training establishment.

The strength in this project evolves around the community-based continuing education service offered a variety of consumers. This project is particularly sensitive—by design—to the needs of the consumer, and all educational programs are built with and around the defined needs of potential students. An obvious weakness is the size of the catchment area in relation to the small full-time staff (one psychiatrist and one psychologist).

Psychiatric Education for Nonpsychiatric Physicians

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Objectives

The Continuing Education Program in Psychiatry at the University of Washington attempts to teach mental health skills to nonpsychiatrists who are in "helping professions," especially in rural or sparsely populated areas of the State. The program also tries to identify areas of mental health need within its purview, to educate the community at large to the extent of mental health problems and the need for services to deal with these problems, and to train others to perform these educational functions. Ideally, all persons in the "helping professions" who come into contact with segments of the population which tend to develop emotional difficulties should be able to recognize the early signs of emotional difficulties, possess the skills to deal with small or noncompounded problems, and know when and where to refer. There should be close cooperation between the referring personnel and those receiving the referral. The program, therefore, is oriented toward direct skill acquisition, the training of those who train others within their communities, and community organization (helping communities organize to meet their own training and care-giving needs).

Decisions on priorities and areas of need are reached through consultation by the program staff with consumers (as typified by the advisory group), discussion with those working in particular communities or with particular population groups (through community surveys by the staff), data received from statewide groups which have done surveys of needs in their particular specialties (nursing associations, Washington Association for Mental Health, the State Department of Social and Health Services, the Bureau of Indian Health, etc.), and consultation with Federal bodies (e.g., NIMH, Region 10).

Methods and Content

Training is oriented toward skill acquisition and attitude change. The courses have an experiential basis: trial and critique by teacher or group; use of videotape to suggest alternative approaches to problems; and provocation videotapes or films to promote discussion, self-awareness, and attitude change. These are supplemented by didactic backup material (reading lists, handouts) and, when possible, followup with videotapes of lectures and demonstrations.

Content areas, chosen with consumer consultation, include: treatment of alcoholism; recognition and treatment of drug abuse; sexual counseling (including abortion counseling and family planning); behavior modification techniques (especially as applied to children); family counseling and group therapy techniques; special problems of minorities and the poor; and recognition and treatment of depression.

Topic- or problem-oriented courses (e.g., depression; emotional problems of children) are large (100–200 students), statewide, interdisciplinary, and last 1 or 2 days. Community-oriented courses treat several topics suggested by the particular community in a series (4-6) of day-long (6–8 hours) workshops, occurring over several months or years. The problems to be addressed at large conferences are chosen through consultation with statewide organizatoins and through feedback from previous conferences; topics for community workshops are chosen by members of the community as being those most relevant to the problems of that particular community.

Students

There were approximately 1500 students during the first 3 years of the program, and an estimated 700 in 1972. Approximately 35 percent were nonpsychiatric physicians; 10 percent nurses; 35 percent social workers; 8 percent school personnel; and 12 percent community mental health center personnel of all professions. The program has deemphasized training of nonpsychiatric physicians, so the percentage of physician students will drop during the next 2 years.

Students are already "inservice." They are self-motivated; that is, they have either had some mental health training and are eager for more, or they are aware of mental health issues in their daily work and want to know how to approach them. Community-based courses may enroll all the school counselors, all the Public Health nurses, all the community mental health center personnel from a target community and environs. Students at large conferences are often designated by their agency or organization to attend the course and are expected to pass on the skills and information acquired upon their return home.

Program Evaluation

Efforts at evaluation of courses have focused on brief questionnaires to elicit subjective reactions and to measure attitude change. An evaluation consultant is designing measurements of skill acquisition. The results of these surveys, and followup on attitude change, should be available shortly. The questionnaire for each course is designed to fit the objectives of the course as previously defined by consumers and students.

The training-of-trainers program just inaugurated will generate written and audiovisual materials which can be used by the trainer-students in their future training activities. Efforts are being made to develop teaching modules which can be used for inservice training purposes in areas of the State too remote to be covered by more conventional means. A video-tape library of lectures and social service agencies, etc., with playback equipment is to be furnished in some cases by the Department of Social and Health Services.

The emphasis of the program has changed from the training of nonpsychiatric physicians to training those in other helping professions. This change in emphasis was accompanied by and was to some extent the result of more community involvement through community surveys and input from the advisory group. The program hopes to foster more cooperation among various continuing education programs in the State. An informal arrangement has evolved with Social and Health Services, and a committee of continuing educators, sponsored by WICHE, has been set up. It is also possible that the program will expand its "broker" functions: identifying or being made aware of specific problems in particular geographic areas or segments of the population, finding an "expert" on dealing with such problems, and helping trainer and trainees set up a specific workshop to address the problem.

The major strengths of this Continuing Education Program in Psychiatry are its flexibility, which permits giving the consumers exactly what they want and need; innovative teaching techniques, which have led to a high degree of "customer satisfaction"; and maximum use of personnel and existing resources through cooperative ventures, brokership, and dissemination of audiovisual teaching materials (videotape library).

On the other hand, the community surveying effort, begun several months ago, has shown the surprising extent of consumer and agency needs still remaining at all levels and in all parts of the State. The program has not reached many parts of the State because of lack of money and staff. More "temporary" teachers and consultants would be needed. Some large areas of mental health concern have not yet been addressed; e.g., legal aspects of mental health care (commitment, court procedures, etc.), problems of large-city minorities, hospitalization (both in mental and in community hospitals), etc. Evaluation efforts and followup have been weak up to the present time.

The program does feel that because of its flexibility and willingness to experiment and listen to the needs of consumers and potential students, with larger budgetary and staff support, it could become an effective stimulus for and coordinator of almost all mental health continuing education programs in a small (population and area) State like Washington. The redirection of Federal support for training makes it even more important that alternatives be developed to bring mental health information and care to the consumer.

Psychiatry–GP–Postgraduate Education

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Objectives, Methods and Content

The general objective of this postgraduate educational program for general practitioners and other nonpsychiatric physicians is to improve their competence in the diagnosis, treatment, and prevention of mental health problems. These postgraduate seminars in psychiatry for nonpsychiatric physicians are divided into three separate courses: (1) a basic course in psychiatry, (2) an advanced course in psychiatry, and (3) an advanced course in human sexuality. These courses each consist of 2-hour meetings on Tuesday evenings for 21 weeks.

There are specific educational objectives in each course. The basic course in psychiatry offers a clinical orientation to the principles and techniques of psychiatry as well as to their application in the practice of the nonpsychiatric physician. The first hour lecture on a basic topic is followed in the second hour by small group meetings of the physicians with a psychiatric preceptor. In the first hour, diagnostic information, interviewing techniques and methods of therapy including the use of drugs and supportive psychotherapy appropriate to the nonpsychiatrist are discussed. One goal is to educate the practitioner to make a differentiation between minor emotional problems and psychiatric illness. Another goal is to heighten the awareness of the nonpsychiatrists to the meaning and importance of their own feelings and behavior in their practice and how these may affect the doctor-patient relationship. In the second hour, patients are interviewed from the Lafayette Clinic or from the practices of the physicians themselves. Some of these interviews are conducted by the nonpsychiatric physicians. Following the psychiatric interview, there is a discussion of the method of the interview and an appraisal of the psychiatric history, mental status examination, diagnosis, dynamic formulation and potential treatment plan. The physicians in the basic course also receive literature which includes a reading list in psychiatry, a manual describing the psychiatric examination, and a pamphlet explaining the meaning of the diagnostic nomenclature in psychiatry.

The advanced course in psychiatry has a similar format as the basic course. Physicians who have completed the basic course meet for an hour seminar followed in the second hour by a small group clinical demonstration. They continue to pursue the same goals as the basic course with special attention to the interviewing of patients from their own practice and to topics of practical concern such as psychological problems in the medical patient.

One or two special symposia are also conducted each year which are relevant to pressing mental health or societal needs. These topics have included psychiatric emergencies, drug abuse, alcoholism, sleep disorders, etc., and have been determined in conjoint planning with community health and mental health agencies. Intermittently, courses are also given in pediatric psychiatry and learning disabilities.

Students

Fifty or 60 enrollees are accepted in the basic course while 20 to 25 physicians are enrolled in each of the advanced psychiatry and human sexuality courses. The symposia usually attract a total of 200-400 physicians and other health personnel.

Program Evaluation

Systematic procedures are provided for assessing the needs of the potential participants. Written and/or verbal evaluation of all three courses and the symposia are elicited of the faculty and the physician-students. All express their opinions of the programs and course content which are reviewed by the project director and used for restructuring the courses. Flexibility in the curricula is accomplished by involving the physician-students in program planning at the onset of the courses. The human sexuality course also includes an attitude and knowledge assessment at the beginning and at the termination of the course. In the basic course, TV tapes of physician/patient interviews are made and played back for self and group evaluation in some small groups. Evaluation of the physician-students' progress in course goals has also been made by observing their interviews with their patients in the physicians' own offices.

The community physicians who have enrolled in these courses in the past have been most enthusiastic and have been the chief unsolicited source of future enrollees in the program. The specific curricula and design of the three courses and the symposia as outlined in the most recent grant proposal have the potential for replication elsewhere. There has also been an innovative attempt to integrate the program with interdisciplinary personnel (nurses, psychologists, social workers, etc.) at selected sessions in the basic and human sexuality courses as well as the symposia. This year the format of the basic course has been only slightly changed relative to the lecture series. The advanced course in psychiatry will highlight interview and psychotherapeutic approaches to the various psychiatric disorders seen in medical practice. The human sexuality course has been broadened in the areas of family and marital counseling and in sex education.

The strengths of this program lie in the relevance of its seminar and symposia material for the psychological aspects of medical practice. It is enhanced by the patient interview and discussion each session. The weakness of the program might be better evaluation and followup of the enrollees to see what measurable affect the courses have on their medical practice.

Psychiatry–Continuing Education of Physicians

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MH07191 1960–1973

Objectives

Since its inception the continuing education program for physicians has sought to identify those persons throughout the 13 western States most closely involved in direct mental health continuing education for physicians and has attempted to work with them to increase their own skills and sense of shared purpose. WICHE engaged in a certain amount of direct continuing education, particularly during the early years of the program, but as grants were made available to departments of psychiatry and to medical societies, WICHE has allocated an increasing proportion of its resources to dealing with continuing educators, rather than with the primary physician.

With the exception of the urban areas in California, most mental health continuing educators tend to be relatively isolated from each other and tend to engage in continuing education as a part-time activity. Accordingly, WICHE has seen it as critical to develop in this group a greater involvement in the shared task and a greater personal commitment to the provision of a continuing education program for primary physicians.

Methods and Content

Until 2 years ago the major methods for achieving the objectives mentioned above have been of two kinds. First, there has been an annual meeting of teachers in continuing education programs, and second, there has been a constant effort to maintain personal contact with these teachers by means of visitations, special meetings and conferences, national get-togethers, and invitations to selected continuing educators to meet in Boulder periodically.

Two years ago a second annual meeting was developed, bringing together program directors of mental health continuing education programs. These meetings have been more administrative and mutually supportive in character and have had as their objectives the strengthening and expansion of continuing education programs.

The annual teacher training institutes have traditionally been divided into two phases. One phase has revolved around specific content areas and an effort has been made to bring to the attention of continuing educators recent developments of a substantive character which they could utilize in their own continuing education programs. In recent years these content areas have included psychopharmacology, family therapy, geriatric psychiatry, child psychiatry, mental illness among physicians, and marital counseling. The second phase of the annual teacher training institutes has dealt with continuing education methodology and the institutes have had the opportunity to consider such content areas as ideology of adult education, use of computers in continuing education, development and implementation of a telephone network for continuing education, and the use of videotape equipment in continuing education.

In developing the annual teacher training institutes and program director's conference, a small planning group has typically been brought together to develop an agenda, plan the list of invitees and the site and time for the meeting, and then the WICHE staff has taken over to carry out these plans and to serve as the secretariat for the meetings when held.

Students

During the early years of the mental health continuing education programs, WICHE worked directly with primary physicians and approximately 5–600 physicians have been involved at one time or another as participants in continuing education programs. In recent years, as WICHE's programs have moved toward primary involvement with continuing educators, the number of trainees has decreased, but an effort has been made to involve all known continuing educators of primary physicians as students in the program. Perhaps 60 to 80 continuing educators have been involved each year, and because of the rapid turnover of such people, relatively few continuing educators have participated in several meetings. More often than not a particular student will participate in one or two meetings and then no longer participate as his own job assignment moves away from continuing education. Over the years perhaps 400 different continuing educators and teachers have been involved in the WICHE program.

The vast majority of these continuing educators have been psychiatrists, although within the last 2 or 3 years other disciplines have begun to be represented. These psychiatrists have typically been members of departments of psychiatry or clinical faculty whose activities have included responsibility for the continuing education of primary physicians.

Program Evaluation

WICHE has seen as its major objective the expansion of continuing education for primary physicians, and thus its primary data for evaluating its efforts has been the evidence of an increase in the number of programs and an increasing evidence of program intensity. WICHE has seen fit to persuade eligible grant recipients to apply for grant support to establish their own general practitioner continuing education programs and has been reasonably successful in this effort. Nearly all departments of psychiatry in the 13 western States are now directly involved in G.P. continuing education and the programs have tended, until quite recently, to be characterized by increasing involvement and centrality of general practitioner continuing education among their high priority activities.

It has been difficult for WICHE to achieve its objectives to the extent it would like because so little staff support at WICHE is available to this project. Nearly all of the grant money WICHE received in the project goes to support the annual conferences and necessary staff and participant travel. A full-time person has never been employed by this project. WICHE has been no better off than most of the medical schools providing direct continuing education, in that direction of the program has been a part-time assignment for that person who has other areas of responsibility at WICHE. The director of the G.P. continuing education program has always been the head of the WICHE mental health program and has not been able to allocate more than 15 percent of his time over the year to participation in this program. The same holds true with secretarial staff. The administrative secretary of the G.P. continuing education program has always been that person who serves as the secretary to the mental health program director and again, relatively little time has been available for this activity. WICHE has not been successful at getting that kind of grant support which has made it possible to devote even half-time to this activity.

In recent years it has become apparent to WICHE that continuing education aimed exclusively at an audience of primary physicians needs to give way to efforts to facilitate continuing education in all of the mental health related professions and future plans include moving into multi-disciplinary programming, as well as seeking enough grant support to employ full-time personnel.

Psychiatry–GP–Postgraduate Education

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MH08599 1964–1974

Objectives

The general objectives of this course are to improve the knowledge and skills of the family physician to more adequately care for the mental health needs of his patients. Specifically, this entails the acquisition of factual psychiatric information of clinical entities, their diagnoses, course and treatment and the special skills to unveil them by training in interview techniques. To understand the subtleties of emotions, the common growth and development of emotional pathologies, the treatment of emotional disorders with psychopharmacologic and psycho-social methods and integrate the whole with the family, work, play and social life of the community—these are additional specific objectives.

Methods and Content

The method of training involves first the participation of the student-physician group in the design of the course content to meet their specific needs. Since the groups are limited to less than 25 persons, the presentation of material is done by a combination of the lecture–discussion method followed by a live case presentation with summarization of the interview findings and opinions in the presence of the patient and the class who act as fellow consultants. The patient is given ample opportunity to explore his feelings about the interview and the interviewers and his reactions to the consultation and its revelations and internalizations.

In practice over many years, the usual course design involves ten sessions of basic psychiatry with presentations of depressive reactions, psychoneurosis anxiety, conversion reactions and paraneurologic entities, agitated and manic states and schizophrenic reactions, alcoholism and drug abuse, psychopharmacology and physical therapies, principles of growth and development, psychosexual differentiation and outlines of therapy (covered more extensively in a later series of ten sessions after a month interim). Before termination of the first ten sessions a half session is devoted to evaluation by questionnaire and comment to the teacher or his elected representative in the class as discussed later.

The teaching-learning sessions are arranged to be 2 to 2½ hours in length and given one time a week for 10 consecutive weeks, then interrupted for a month during which time the student tries his new knowledge in his practice and explores his personal reactions. When the group regathers for the second ten sessions, these experiences are recounted and discussed vigorously and personally and the class is launched into a course on applied practical therapy including practicum sessions with critiques using listening therapy, process-oriented therapy, crisis intervention techniques, principles of client centered nondirective therapy, confrontation and sensitivity techniques, conventional analytic, co-therapist and small group techniques as in family therapy. Specific thrust-building and observational improvement methods are taught to increase skills in deriving covert underlying patterns of personality.

Each 10-week session represents actually 24 to 30 hours of class time plus assignments for reading, movies, etc., as the nature of the class prescribes. In total, students who complete the 20-week time are in session 48 to 60 hours with appropriate time credit hour for hour to those who use the time for continuing education training credit or physician award system, etc.

Students

Students vary from 100 percent MD's to about 40 percent with the remainder usually psychiatric or charge and educator nurses and an occasional clergyman, psychologist and social worker team from local mental health clinics. An ideal class size is between 10 and 15 students with classes held in local hospitals where the students work and to which the instructor commutes weekly for the usual evening classes. The age range of students runs between 24 and 65 years with the median 40 for physicians and 28 for nurses and younger for the occasional nursing assistants. The physicians vary from general practitioners to radiologists and even pathologists with a number of pediatricians and internists and occasional surgeons. Nurses and assistants range more on personal inclination than on specific special training though the psychiatrically oriented predominate.

Program Evaluation

Program evaluation is a part of the course with a simple questionnaire covering expectations, failures, known changes in practice of attitude, suggestions and criticism of teaching, course structure and any particular items of personal feeling. Because of the association of the instructor with the University of Wisconsin Postgraduate Medical Education Department, the services of trained program evaluators are available. Up to recently, the simplest of endorsements based on return of class participants and their open, frank comments and suggestions have been used to evaluate teaching, course content and method. (A site visit was totally oriented around voluntary participant support covering distances to the evaluation site of up to 250 miles.)

This type of course is simple and easily replicated at all levels. It is unique in that it is small in unitary size, personal and heavily participatory for all, easily adjusted to local demand and customary practice needs, as well as to new developments in teaching and community psychiatry. It is strong in bringing the University to the student, in convenience and local values of security of patients (though some are transported by the instructor) and in involving the hospital, the administrator and local psychiatrists with the University instructor or team. Its size makes it expensive in time, effort and expenditure per student but its accomplished results in achieving change in the practice and attitude toward emotional disorders merits its monetary expense in hard, practical terms of local community responsibility versus distant and dehumanizing strange institutional experiences for patients and their referring doctors. The town and gown desensitization value is inestimable. In a dozen communities in this State of Wisconsin the programs have been well approved.

Its weaknesses are small size, special demands of scarce instructors, limited clientele and the slow process inherent in overcoming and recognizing worth in the psychiatric experience. Consumer evaluation has not been done.

PART 2

CONTINUING EDUCATION FOR PSYCHIATRISTS

Office of Continuing Education for Psychiatrists

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MH10932 1967–1974

Background

The Office of Continuing Education for Psychiatrists was established at the American Psychiatric Association Headquarters on the recommendation of a Task Force on Continuing Education for Psychiatrists.

The Task Force made a survey in 1966 and 1967 which disclosed a dearth of opportunities for psychiatrists in continuing education activities. Out of 1,847 institutions, societies, and other organizations surveyed, 51 gave a total of only 73 courses for continuing education of psychiatrists. This finding coincided with what was revealed in the American Medical Association's (AMA annual (1967) listing of continuing education programs then existing in psychiatry. That list seemed to stress primarily the training of others in psychiatric matters, rather than psychiatrists, with multiple courses for general practitioners in the psychological aspects of medicine.

The Office of Continuing Education for Psychiatrists (O/CEP) opened in September 1967. The Task Force, which met for the last time in November 1967, recommended that it be dissolved as it had completed its mission; that it be replaced by a group of advisors to the project; and the members be appointed by the APA Medical Director and the O/CEP Director.

The first Advisory Group met in February 1968; scheduled two regular meetings a year at APA Headquarters in Washington, D.C.; and recommended that two specific projects be actively undertaken. The first, a Psychiatric Knowledge and Skills Self-Assessment Program (PKSAP), following the successful example of the American College of Physicians' (ACP) Medical Knowledge Self-Assessment Program (MKSAP); and the second, a survey of a representative APA District Branch—the Illinois Psychiatric Society (IPS) was chosen—to gather information about the practice habits of the members of the branch and their recognized wishes and needs for continuing education. The survey followed the systematic approach used by the AMA in its Utah study of medical practitioners' view of their continuing education. Implementation of these two proposals for action was undertaken early in 1968 with the hope they would lead eventually to development of programs of continuing education designed to meet the needs of all APA Area Councils and their District Branches. In addition to the IPS activity, the Northern New England District Branch, the Georgia District Branch, the South Florida District Branch, and the Ohio District Branch conducted surveys using various adaptations of the IPS model. Accounts of these and other undertakings by the O/CEP are described in a study entitled PROSPECTS AND PROPOSALS: LIFETIME LEARNING FOR PSYCHIATRISTS.

The decisionmaking process in planning and implementing the continuing education program is participated in by the O/CEP, the Medical Director's Office and the O/CEP Advisory Group.

Objectives

The O/CEP has worked for 5 years to build a continuing education program for APA members and other psychiatrists. It has successfully developed an instrument for individual continuing education using the self-assessment technique. The objectives and responsibilities of the O/CEP and its Advisory Group are to: plan and supervise the administration of the Self-Assessment Programs (the first in 1969 and, the second and current, in 1972); manage the Statistical Data Analysis of the 1972 Self-Assessment Program; act as liaison to encourage the APA Area Councils and their District Branches to participate in the self-assessment and to survey their members' attitudes and their needs and desires for individual continuing education as a result of participation in the self-assessment; and to develop regional workshops to train "teachers" of continuing education.

Method and Content

The current (1972) Self-Assessment Program, PKSAP-II, was planned on a functional, problem-solving, patient-oriented approach pointed toward stimulating motivation in psychiatric practitioners by emphasizing clinical relevance and the attainment of the goal of clinical competence and its maintenance throughout lifetime practice.

Instead of dividing the test into content areas (Basic Sciences, Social-Administrative-Community Psychiatry, and Patient Management), the overall emphasis is on various aspects of patient management. There are approximately 240 erasure-disclosure questions comprising eight (8) clinical cases on patient management problems and 240 multiple-choice questions, with 80 devoted to problems in diagnosis, 80 to problems in treatment and 80 to issues dealing with problems of current concern to psychiatry.

The APA and its O/CEP do not have a "training program" in which certain methodologies are used, specific content areas covered and courses given. Neither are there "students" from various disciplines, as such, represented in our program. Our clientele consists potentially of the nearly 20,000 members of the APA.

Program Evaluation

The APA Self-Assessment Program is but one of such programs previously carried out or planned by the national medical specialty organizations and endorsed by the American Medical Association's House of Delegates and Board of Trustees.

Program evaluation as it is now planned will be further and more sophisticated statistical analysis with personnel and consumers both contributing.

Individual results of the self-assessment remain confidential and are made known only to the individual testee. The test responses will eventually be analyzed thoroughly and correlated with biographical data supplied by the testees. Each testee will be given opportunity to compare his score with norm tables and with his own peer group as well as other groups. An item analysis will be prepared and distributed on request. The norm tables and item analysis have been prepared by analyses of examinations completed on a "closed-book" basis. The biographical data collected include location of practice and nature of practice. As a result, the APA, the APA's Area Councils and the APA District Branches will for the first time be able to assess their constituencies' needs. In the years following, continuing education programs can be geared to those needs and members can take advantage of such programs.

The self-assessment technique is an innovative approach to continuing education in mental health. The APA was the second of the national medical specialty organizations not only to use the self-assessment approach but to use it a second time and to plan to use it regularly.

Psychiatry–Continuing Education

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MH12152 1970–1974

Objectives

The Hahnemann Medical College and Hospital continuing education programs in psychiatry are broadly based upon the premise that the practicing physician must be aware of emotional factors which appear concomitantly with physical disorders and that, further, the physician must be able to deal effectively with the emotions manifested by his patients. The programs are oriented toward improving the quality of medical care by affording practitioners the opportunity of integrating the relationship of emotional factors to the physical in the overall management of their patients.

It has been reported that up to 70 percent of all persons who enter a general practitioner's office are suffering from no organic physical disorder but that their complaints are of a functional nature whose origins can be traced to emotional factors. In educating the general practitioner in psychiatry, this program intends to alert him to the psychodynamics of such reactions in his patients as well as to allow him to examine his own beliefs and attitudes toward his patients so that, where appropriate, they can be altered to enhance the physician-patient relationship.

Similarly, courses are offered relevant to the practicing pediatrician, obstetrician-gynecologist and urologist. These areas of instruction are particularly applicable to the practices of these specialists but concurrently can be effectively relevant to the general practitioner. Objectives in this area include supplying a maximum of clinically useful information to these physicians such that they will be able to achieve an understanding of the dynamics of emotional problems encountered in their respective areas of specialization.

Finally, while this is frequently the most difficult in terms of recruitment, the program is also involved in the continuing education of psychiatrists. In this area, the goal is to present these physicians with an inventory of current knowledge conveying to them new developments in treatment modalities as well as to further their knowledge of psychiatric disorders and techniques.

Methods and Content

Methods of instruction have encompassed a variety of methods including didactic courses, training in interviewing, case presentation and symposia. During the past academic year, each of the above was utilized in the following courses:

1. *Seminars in Psychotherapy*—This course focused upon patient management through practical demonstration, and is comprised of thirty 2-hour sessions which meet on a weekly basis. One-way mirror observation of interviews provided the basic format. These interviews are followed by a discussion of the patient from a descriptive, dynamic and therapeutic point of view.

2. *Sexual Problems in Medical Practice*—The information that can be gleaned from this course can be of value to general practitioners and specialists (i.e., obstetrician-gynecologists, urologists) who deal with people and become involved in their marital and sexual problems. The format is one of lecture-discussion. The course meets for 12 successive weeks, 2 hours per week.

3. *Adolescence and the Youth Culture*—Lectures followed by discussion are presented concerning a broad range of adolescent problems. The course is comprised of 10 weekly 2-hour sessions.

4. *Psychological Pediatrics Conference*—The course is designed to acquaint the specialist and general practitioner with clinical methods of handling difficult problems in children and adolescents, and a lecture-discussion format is utilized. The course meets for 27 weeks for a total of 1½ hours per week.

5. *Psychiatry for Dentists*—Designed to provide the dentist with a knowledge of psychiatry which will serve to enhance the dentist's interaction with his patients. This course has been given annually for the past 4 years with anywhere from six to twelve dentists attending. The course generally meets for a 10-week period for 2 hours per week.

6. *Seminars at Sea*—This is an additional and innovative program which allows physicians to combine an educational experience with vacations with their families. The cruises generally may last from 7–14 days and are designed to provide continuing education for psychiatrists and other practitioners.

It is important to note that while the courses outlined above were presented at Hahnemann there were also a series of programs in which members of the faculty lecture on various topics to staff members of hospitals. Further, there are currently two ongoing programs geared to postgraduate education for psychiatrists. They are offered at two hospitals in the Philadelphia area and consist of monthly conferences designed to relate to their staff new developments in treatment modalities as well as to further their knowledge of psychiatric disorders and techniques.

Participants

There were approximately 169 persons who attended the aforementioned courses. Registrants for symposia and workshops have included psychiatrists, psychologists, social workers, mental health workers, teachers, nurses, administrators and others.

Speaker's Bureau—The entire faculty of the Department of Mental Health Sciences is available to participate in postgraduate education programs. The composition of the faculty includes 159 psychiatrists, 22 psychologists, 23 social workers and others. These faculty members contribute to postgraduate education in many ways—conducting seminars, giving lectures, etc.

Because of the heterogeneity of interests and specializations found among the faculty, the staff has been able, upon request, to supply speakers on a variety of subjects to both professional and nonprofessional audiences in the area. While these efforts are not always initiated by the postgraduate education office, they do make significant contributions to the psychiatric education of those attending.

Program Evaluation

Upon completion of courses, participants are asked to complete a questionnaire detailing their general impressions of the course including an evaluation of the methods of presentation and course content. The respondents have indicated general satisfaction with the courses and have made suggestions as to new courses they would like to see presented. Input such as this allows program staff to examine the programs and make the adjustments necessary to assure their success.

In terms of accreditation for Continuing Education in Psychiatry, the program director has set into motion a plan for a consortium of accredited programs through the Pennsylvania Medical Society and the Pennsylvania Psychiatric Society. The Pennsylvania Medical Society will accredit the Pennsylvania Psychiatric Society which in turn will establish through its Committee on Education a loosely affiliated group of statewide organizations and institutions which will have ongoing programs accredited through the parent organization. Dr. Fink is Chairman of the Education Committee and is working with the Pennsylvania Psychiatric Society and the Pennsylvania Steering Committee for Continuing Education to develop an effective system for psychiatrists to achieve the needed credits.

This program has some unique features which are applicable on a national level. The basic problems encountered in developing and sustaining a continuing education program in psychiatry are related to recruitment of "students," mounting a course which is both useful and helps the consumer improve patient care. The method which has been contrived is directed to both of these problems. In selling continuing education programs to institutions there is no longer a dependence on enticing each participant to the program. The program is able to reach a well-developed unit as a potential audience. It becomes easy to plan a program with a D.M.E. or a member of a staff and have him work with the program as a consumer ombudsman to making the program design and material relevant to his constituents. The hospital or group with whom staff negotiates pays an amount sufficient to cover the honoraria for the speakers or discussion leaders. They may pay a small additional administrative charge but these charges do not cover the costs of administering the program.

In terms of replicability, it is this method of the academic center acting as an expeditor of continuing education for a hospital or an already established group of physicians which is significant. This concept has evolved over a period of years and has already been copied by other continuing education groups.

Continuing Education–Psychiatry

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MH11796 1969–1975

Background

The Institute of the Pennsylvania Hospital in collaboration with the Department of Psychiatry of the Medical School of the University of Pennsylvania is currently sponsoring its Fourth Annual Continuing Education Program for Psychiatrists in the Greater Delaware Valley Area. This program, in response to questionnaires sent in 1972 to 250 of the over 600 psychiatrists in the area, introduced a wide variety of new activities including seven formal seminars, an all-day symposia on Mental Health Administration, a number of Saturday morning Film Seminars, Workshops on the Self-Assessment Test for Psychiatrists and a formal course on Medical Hypnosis. In addition to attracting psychiatrists on a regional basis from Delaware, Maryland, New Jersey, New York and Pennsylvania, the program is co-sponsoring seminars with hospitals outside the Greater Delaware Valley Area. Each faculty member has been selected on the basis of proven effectiveness as a teacher as well as thorough knowledge of his subject.

Many are senior members of the Medical Staff at the Institute of The Pennsylvania Hospital and the Department of Psychiatry of the University of Pennsylvania, and some are internationally known and respected in their field. This program is fully accredited by The Council on Medical Education of the American Medical Association and thus offers credit opportunities for the Physician's Recognition Award. This award given by the American Medical Association is now required for continued membership in The Pennsylvania Medical Society.

Decisionmaking is predominantly initiated by the Program Coordinator with frequent consultation with the Program Director. Additional advice comes from the Director of Continuing Education for Nonpsychiatrists. All three psychiatrists are members of the Institute's Continuing Education Project Operating Committee (CEPOC) and thus oversee and integrate all continuing educational activities.

Methods and Content

Didactic seminars, group discussions, and practical work with patients within a framework of seminars characterize the usual approach. Recognizing differences in affinity of students for personal interaction in learning situations, the use of psychiatric films moderated by a discussion leader has proved an effective sought-after experience by many students.

Courses given include Psychopharmacology, Self-Assessment Test Workshop, Family Therapy, Behavior Therapy, Films in Psychiatry and the Behavioral Sciences, Group Psychotherapy and Medical Hypnosis.

Affiliate programs for nearby hospitals exist as well. In the spring of 1972 a 10-hour seminar was sponsored at Danville State Hospital on Psychopharmacology. This was attended by 19 psychiatrists for a total of 190 credit hours. This initial experience has suggested the value of establishing three more courses for the coming year and has established the fundamental value of reaching groups of psychiatrists in their own locale. Also, regarding future funding, State hospitals and agencies are likely to be able to support such programs as this.

The 1972–73 Program features a special all-day conference on Mental Health Administration. It used a social system's approach to the organizational mental health facilities. Topic areas included the concepts of primary task, goals, intraorganizational subsystem relationships and organizational boundary management. Conference leaders used their own experiences as case examples and involved the various participants in discussing their own experiences. Discussions included the development of administrative systems, in particular the uses of computerized record systems, and the development of cost accounting procedures in the development of processes for program evaluation.

Students

The Delaware Valley has more than 600 practicing psychiatrists. During the last year and a half, almost 100 different psychiatrists have attended nearly 1600 credit hours of Category I instruction. Of the 100 students, 20 were employed and working in Community Mental Health Centers, 14 were employed and working in State hospitals including the Superintendents of two State hospitals in Pennsylvania and one Director of the Veterans Administration Hospital in Maryland, 14 psychiatrists were employed by general hospitals, and six in miscellaneous governmental positions, for example, U.S. Naval Hospitals, Veterans Administration Hospitals, etc. Thus, 54 percent were in Federal and State funded institutions and the remaining 46 percent were in private practice. On occasion, certain other qualified mental health professionals have been admitted, and were in primary treatment positions with either a doctorate or masters degree or the equivalent.

Program Evaluation

Recognizing the necessity of evaluating the program, students have been given a simple evaluation form before, immediately after, and 6 months after each seminar. From this data as well as spontaneous comments from students over the years, the program is constantly reshaped. Both the teaching faculty and students enter into this process.

The impact on the community is in evidence by a definite awareness of this program in the four-State region for Continuing Education in Psychiatry. A questionnaire in 1972 to 250 of the 600 psychiatrists in the Delaware Valley area has revealed the increasing interest in the program.

Changes have been made principally to create seminars for specialized groups, for example, Mental Health Administrators. Seminars such as Films and Medical Hypnosis have attracted students who have not previously attended the program.

The major strength of this program lies in its faculty of senior psychiatrists picked for their effectiveness as teachers and knowledge of their particular subjects. Drawn from the Department of Psychiatry, School of Medicine, University of Pennsylvania, as well as the Institute of The Pennsylvania Hospital, the faculty has great breadth and depth in both academic and clinical acumen and experience. The major weakness has been the common difficulty of developing a detailed demographic listing of eligible psychiatrists and their locations in this large region.

The program is innovative because it uniquely combines the resources of a leading university and a leading private mental hospital, thus offering students and faculty the best of both.

Continuing Education in Psychiatry

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MH11783 1969–1973

Introduction-Objectives

The continuing education program at the New York Medical College-Metropolitan Community Mental Health Center has been prepared in conjunction with those to whom it has been and will be directed; namely, the nonpsychiatric physician, the practicing psychiatrist and other mental health professionals. A variety of programs that already have been organized and are to be implemented in the future are also directed to those practitioners in the CMHC catchment area and as such will serve to acquaint them with the workings of this Center on a more meaningful level. Ultimately, the goals of the programs are several: to upgrade the quality of care in this area; to provide training in newer therapeutic modalities that will enable more people to be reached than ever before; and to assure that physicians and others are kept abreast of the most recent advances in the field.

Methods and Content

1. Postgraduate Instruction in Group Psychotherapy

The Department of Psychiatry offers postgraduate instruction in group psychotherapy for psychiatrists as well as special courses to which other professionals may be admitted who desire to acquire knowledge of this therapeutic modality.

The goal of postgraduate instruction in group psychotherapy is to train psychiatrists in this fast-growing and increasingly important field. It is only in recent years that some residency programs have begun to offer such training. Because of this, there are a great number of psychiatrists who have had no experience in group psychotherapy. Those who have may wish to update their knowledge or become acquainted with recent advances in the field. In addition, there is a need for the development of skilled teachers with a comprehensive knowledge of group processes who will be able effectively to impart this to others and so meet the expanding training needs.

The part-time training program consists of 28 2-hour evening sessions divided into a fall and spring semester of 14 weeks each.

A unique approach to the presentation of the theory and practice of group psychotherapy has been developed to provide a vivid and meaningful learning experience. Each session begins with a lecture on group psychotherapy and related topics. Where new advances in the field of psychiatry are made and where this knowledge is considered necessary to update the psychiatrist's general competence, such material is included in the lecture series. In addition, candidates observe the treatment of an ongoing, long-term, intensive psychotherapy group. This is followed by small group discussions with instructors during which both lecture material and dynamics of the observed group psychotherapy session are examined in greater detail.

2. Postgraduate Instruction in Family and Marital Therapy

The postgraduate course of instruction is designed to train psychiatrists in the rapidly expanding field of family therapy. The program has been structured to meet the needs of the psychiatrist with little or no prior training in family techniques and also for those who wish to remain current with new developments and update their family therapy skills.

In addition there is a need for the development of well trained teachers with a firm background in family process who will be able to teach these skills to others and so meet training needs.

A major aspect of the program is training in marital problems. Included in this area is intensive study of conjoint therapy of couples and particular problems such as infidelity, promiscuity, divorce, marital adjustment, decisionmaking, childrearing, money, roles, and pattern of incompatibility. The course presents the most up-to-date techniques from an eclectic viewpoint.

The theory and practice of group psychotherapy with families including married couples' group psychotherapy, multiple family therapy, multiple impact therapy and other recent developments in the field are covered in this series.

The part-time program consists of 20 2-hour evening sessions. In addition, candidates may observe the treatment of family problems. This is followed by small group discussions with instructors during which both lecture material and dynamics of the treatment session are examined in greater detail.

3. Postgraduate Instruction in the Diagnosis and Treatment of Sexual Disorders

The training program in human sexuality and in the diagnosis and treatment of sexual disorders is designed to train physicians in this rapidly expanding field. The program has been structured to meet the needs of the physician who wishes to learn the most recent developments in the implementation of sexual therapy for a wide range of sexual dysfunction.

To understand human sexuality, both normal and abnormal and to diagnose and treat sexual disorders, the clinician needs to have a background not only in psychiatry and the behavioral sciences but also in sexual anatomy and sexual physiology.

The program has been designed with these factors in mind in order to provide a comprehensive and in-depth examination and overview of specific sexual disorders such as impotence, premature ejaculation, ejaculatory incompetency, frigidity, vaginismus, dyspareunia, the unconsummated marriage, and general sexual incompatibility between marital partners.

The program of instruction consists of 20 2-hour evening sessions. Instructors are recognized experts in the field drawn from a variety of disciplines so as to provide a comprehensive, up-to-date, and eclectic survey of normal vs. abnormal sexuality.

In addition a special clinical training program consisting of the candidate treating a sexually dysfunctional couple in conjunction with and under the supervision of a member of the training staff may be available to certain selected candidates. Admission to this clinical experience is contingent upon satisfactory completion of the seminar series described above. In addition, a personal interview is required.

Participating Students

Since the inception of the continuing educational programs in July, 1969, over 200 students consisting of psychiatrists, psychologists, social workers, psychiatric nurses and other mental health professionals have satisfactorily completed the program for which they were enrolled. Many were from the CMHC catchment area although a significant number were from neighboring States. Interests were extremely varied from the psychiatrist in private practice who wanted to learn group therapy skills, to physicians in other fields, such as family practice, who wanted to learn group therapy skills, to physicians in other fields, such as family practice, who wanted to learn sexual therapy skills. In addition, nonmedical personnel were represented, particularly in the family and marital courses and the sexual therapy courses.

Program Evaluation

The effectiveness of courses was evaluated via the reactions of the participants and suggestions for improvement were implemented in succeeding courses. Auditing of courses by the program director assisted in the development of continuity and cohesiveness and provided teacher evaluation. Acquisition of knowledge was determined using specially prepared test materials at the conclusion of a particular course. This procedure is being expanded.

Practice and attitudinal change in the

physician were assessed. Field studies in which the course participant was visited to determine whether or not new skills were used were attempted. Although findings are preliminary, they appear to be most promising. Some students, for example, returned to their respective institutions and implemented similar courses with their particular hospital staff, although on a smaller scale. Others began to use a new modality in their clinical work. The program hopes to be able to utilize the field study approach more extensively in the future. Finally, the CMHC continuing education program motivated certain individuals to want to affiliate more closely with the Center. Skilled clinicians desirous of obtaining staff positions at the Center, especially one such as this, that serves a large number of lower socio-economic groups, were an unexpected and gratifying incidental finding and one that requires further examination and possible implementation.

The expectation of the program is to train psychiatrists to develop skills in the newer modalities such as group therapy, family therapy, marital therapy, as well as general psychiatry so as to enable these professionals to individually provide more services to more people on an hour-to-hour basis. In addition, other skills, e.g., supervising and teaching, will allow these individuals to establish "satellite" units thus allowing for the dissemination and transmittal of new skills to others who may not have affiliated formally with this particular training program.

In the future, the program will, in addition to continuing to fulfill this function, direct itself toward training the newer mental health professional who may not be a psychiatrist, psychologist, or psychiatric social worker.

Conclusion

The goals of the continuing education programs at this Center have been to integrate both educational and service functions. It is the belief of this Center that the two cannot and should not be separated. As the psychiatrist updates his skills or gains new ones, those for whom he provides professional service benefit. And as he imparts these skills to the newer mental health professionals in a particular community, they and the community benefit. Together the delivery of mental health services to the CMHC invariably is enhanced.

Psychiatry–Continuing Education

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MH10886 1967–1973

Objectives

The continuing education program in psychiatry for nonpsychiatrist physicians is designed to increase the family doctor's interest and ability in managing emotional problems in his practice and to familiarize him with concepts of pluralistic health care and relevant social issues. It promotes a multidisciplinary approach to treating the "whole patient," and provides physicians and nonphysician professionals with an opportunity to learn together. The major reasons for the interdisciplinary approach are (1) the recognition that many primary caretakers in fields other than psychiatry can and do see persons with emotional problems whom they help, and (2) to foster the anticipated interdisciplinary approaches to be used in whatever form of national health insurance and improved delivery systems become operational.

Some of the more specific objectives are to lessen the use of authority in interview situations by teaching the participants when and how to use facilitative, supportive, interrogative, confrontative, and interpretive forms of intervention, both to elicit information and to relieve psychic stress. Other areas that are emphasized include use of psychotropic drugs, referrals, community resources, and generally managing patients with milder psychiatric problems.

Two educational formats are used. One is a series of 12-week courses meeting once a week for 2 hours in local community hospitals. Physicians are contacted and they determine the interest and feasibility of conducting a course in their own hospital. The instructors are psychiatrists on the faculty and on occasion social workers and psychologists. The second format is the weekend seminar which focuses on a specific content area of relevance to the physician in which a psychiatric input could lead to better patient care. Some seminars are oriented to the nonphysician and the content focuses on the psychiatric perspective of the particular problem areas in which these participants are interested.

The title of nine of the 12-week courses conducted this past year was "Common Psychiatric Problems Within a Nonpsychiatric Practice." Other 12-week course titles were "Psychological Aspects of Psychosomatic Illness" and "Diagnosis and Treatment of Childhood Adjustment Problems." Weekend seminar titles this year were "Sexual Problems in Medical Practice," "Difficult Problems in Medicine." and "Understanding Behavior." These titles generally reflect the programs and content covered this year and preceding years.

Students

From the first year of the program, more than 10 years ago, the number of participants has risen extensively. The first year of the program had only 93 participants and the present year has 352 participants including 87 nonphysicians. In 1971–73, there were a total of 6,094 enrollee instructional hours. The largest proportion of physician enrollees have been family physicians with a small number of other specialties represented.

Program Evaluation

Program evaluation started at the inception of the grant and has been continued and expanded. The evaluations focus on satisfaction and the perceived learning of the participants, actual performance on written examinations, and perceived and actual changes in behavior. Further, the evaluations start with the assessment of perceived need of the participants and potential participants, and the results of systematic questionnaires are fed back to instructors so that they may tailor their particular teaching methods or content to the particular group. The results are used in planning new types of courses.

The satisfaction data collected over the last couple of years indicate that over 90 percent of the respondents rate the courses as either "excellent" or "good." Perceived learning has also been generally high, with over 90 percent of the participants indicating they learned "some" or "much." Over 80 percent of the participants indicated there would be an improvement in the way they practice medicine, and 44 percent felt there would be improvement in other activities they engage in as physicians, and 76 percent felt their own personal growth and development had improved. In an attempt to determine what effect the participants felt the course had on the ultimate consumer, the patient, the question was asked about what percent of their patients the physicians thought would benefit from their participation in the course in terms of (1) technical skills and (2) doctor/patient relationship. In terms of technical skills, it was reported that 45 percent of the patients would benefit, and, in terms of the doctor/patient relationship, it was reported that 61 percent of the patients would benefit.

Systematic observed changes in interviewing behavior have been recorded as well as changes in attitudes toward the use of authority in the interview situation.

Several weekend seminars were evaluated and it was found that the participants were highly satisfied with the program, gained substantive knowledge, and changed their attitudes.

There is a current attempt to analyze the effects of one of the programs in terms of improvement of mental health services in the community.

In order to make experiences, evaluations and course methodologies more available to others, the Division instituted a Technical Report Series which has been widely distributed. At present, the Series contains 21 papers concerned with medical and mental health education, and an additional 19 papers in allied interest areas.

In would appear that the major strength of the program is its responsiveness to participants in terms of continual evaluation, feedback to instructors and improved teaching. A weakness of this program is the lack of obtaining an effective measure of the program's benefit upon the ultimate consumer, the patient or the community. This weakness exists, for the most part, because of the lack of adequate financial support to accomplish this kind of complex and crucial evaluation.

Continuing Education in Community Psychiatry

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MH10913 1967–1974

Objectives

The faculties of all the major psychiatry teaching institutions in the Metropolitan Washington, D.C. area sponsor the Associated Faculties Program in Community Psychiatry (AFPCP) in order to provide continuing education in the practical and theoretical aspects of community psychiatry to graduate-level professionals in the mental health field. A three-part approach to this field includes: (1) a Teaching Program for graduate psychiatrists, psychiatric residents and other mental health professionals; (2) a Forum of consultants and teachers expert in community psychiatry; and (3) all-day workshops on community mental health themes.

Methods and Content

The Teaching Program in Community Psychiatry offers a sequence of courses open to the staff members of the participating institutions and to other professionals in mental health programs. Registration is limited to 15 candidates.

The program has shown a steady evolution over the years in response to the continuing feedback from the graduates and the Steering Committee's estimate of training needs in the changing field of community mental health. This is uniquely a part-time program designed to fill the needs of professionals who are occupied during their working days with community-related programs, but who are looking for a systematic approach to the literature, methods and problems of community mental health.

There are three major components to the Teaching Program: a 2-year series of seminars (Social Psychiatry, Consultation, Community Development, Black-White History, etc.), a practicum related to the trainee's own work experience, and a Group Relations Conference. A Certificate in Community Psychiatry is awarded to those who satisfactorily complete the course and field work.

The Community Psychiatry Forum, which includes psychiatrists representing each of the participating institutions, AFPCP graduates, trainees and other interested workers in the fields of mental health and the behavioral sciences, began operating in the fall of 1964. This group, which meets monthly, explores social issues, community problems, and change-strategies relevant to community mental health. The Forum has become a central meeting place for mental health professionals throughout the metropolitan area, helping to establish an abiding colleagueship.

Two or more times a year the AFPCP sponsors all-day workshops for representatives from member institutions and appropriate guests on topics of interest to community workers. Subjects have included: mental health administration, residency training in community psychiatry, the community mental health center, the role and function of the nurse in community mental health, and mental health and the community clergy.

Students

In the fall of 1965 a class of 23 psychiatrists entered the Teaching Program. This group represented a wide range of experience and institutional affiliation. Since then, four additional classes have completed the 2-year course of study. A total of 82 psychiatrists and 13 other mental health professionals have enrolled, and 45 have graduated. The current second-year class has 11 trainees; the first-year class has 13 trainees.

In the first four classes, only psychiatrists were accepted into the program. The rationale was to permit the staff and faculty, together with the trainees, to clarify, as much as possible, the function of the community psychiatrist. Beginning with the fifth class, other mental health professionals were accepted for the purpose of reflecting in training the interdisciplinary nature of community mental health. During the current phase of the program, the AFPCP intends to strengthen the participation of nonpsychiatrist mental health professionals.

Program Evaluation

An ongoing program evaluation has been sought through distribution of questionnaires

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to all graduates and continuing discussions with students and institutional representatives. The questionnaires are reviewed by the Steering Committee, which decides upon changes in the Teaching Program.

The Program's existence has promoted interinstitutional cooperative efforts that otherwise would not have been possible. It has opened up channels of communication that are badly needed—but often do not exist—among educational and service institutions in a large metropolitan area. It has provided a forum where anyone and everyone interested in community psychiatry can meet and talk about problems and programs of common interest. This consortium has created a professional "community" of the many groups and organizations involved in community psychiatric teaching, research, and practice.

Member institutions have both contributed to and benefited from the program. They have provided leadership in promoting community mental health concepts in their own training programs and in the community at large. The Teaching Program's graduates are applying their skills in many programs of training and service in area institutions.

Finally, as an educational experiment, the AFPCP has demonstrated that a part-time faculty and staff can conduct a valuable part-time teaching program in community psychiatry. Although no one in the program has his primary professional identification with the consortium, this has not prevented each participant from contributing his expertise to its effective functioning. The result has been a truly collaborative effort in continuing education.

PART 3

CONTINUING EDUCATION
FOR
BEHAVIORAL SCIENTISTS
AND ALLIED PROFESSIONALS

Parish-Centered Continuing Education for Clergymen

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MH11929 1969–1974

Objectives

In view of the fact that many people with emotional problems turn first for help to their pastor, this program enables clergymen working in the community to meet with mental health professionals in order to strengthen their pastoral counseling skills. It aims to reach a significant number of clergymen, to work with them in meaningful depth and in practical terms which they can apply in their daily experience, and to enrich rather than to supplant their traditional roles within the parish.

The clergyman should be enabled to integrate with his own discipline of pastoral work the skills of interviewing, evaluation, and understanding of emotional and mental problems. By clarifying the objectives and processes of counseling, he may better discriminate what problems are within the range of his abilities and carry through a more effective and focused counseling approach. He should broaden his knowledge of community resources for referral of parishioners, as well as the criteria and mechanisms of referral. In addition he should see the many implications for mental health inherent in the traditional life of the church, along with the opportunities for education and preventive work.

Methods and Content

The fundamental training method is a weekly 2½-hour seminar in which eight to eleven clergymen meet with a psychiatrist, psychologist or social worker for 2 years. The core of the discussion is the current counseling experience of the participating clergymen. In the effort to understand the needs and complexities of each case, many opportunities arise to present factual and theoretical material which can be closely tied in with its practical application. Formal didactic presentations, assigned readings, role-playing demonstration interviewing of parishioners and hospital patients, films, video- and audio-tapes all are used in appropriate contexts; however, the cornerstone of the work remains a case-study approach. Since it is felt that only the clergymen can adapt to their own pastoral counseling role the material presented by the mental health professional, this is considered their task as a group. In this process, the first year men are aided by clergy co-instructors, graduates of the program who serve as role models and share in the leadership of the group.

Although the individual instructors and co-instructors work out the week-to-week development of the material, major decisions regarding the program are made by the faculty as a whole in periodic meetings with the program director.

Relationships with other community agencies are maintained by the program director both directly and through the Cleveland Mental Health Association, the original sponsoring and overseeing body. As new community mental health centers have been established in Cleveland, this program has contracted with each center to conduct a clergy group in its facility as part of its consultative function.

The following content areas are covered during the 2-year sequence of the program: (1) interview technique and case evaluation; (2) the dynamics and skills of the counseling situation as it is related to the pastoral ministry; (3) psychodynamic mechanisms in normal development, health, and illness, and their effects upon common counseling situations (such as marital problems, child-rearing difficulties, adolescence, grief, alcoholism, physical illness, old age); (4) dealing with psychiatric illness requiring referral through the recognition of illness, selection of resources, handling of the referral process, and work with the patient and his family after referral; and (5) utilization of opportunities inherent in the educational and liturgical functions of the religious institution to encourage healthy emotional development.

The course is carried out in seminars lasting 2½ hours and held weekly during 2 academic years, comprising 175 course hours in the full 2-year sequence.

Students

The trainees are ordained clergymen of all faiths who are currently doing active pastoral care in a parish or equivalent assignment. They number approximately 80 per year. All students have had training sufficient to qualify for ordination, which requires a college education plus theological seminary. Very few trainees have had extensive formal training or supervision in the actual practice of pastoral counseling.

The clergymen in the program represent all major religious persuasions and the full social, economic, and racial spectrum of the population of Cleveland. Out of some 2200 clergymen in Cleveland, a total of 226 have participated in the program since its inception in 1967. By the end of this year, approximately 125 men will have completed the full 2-year sequence. A full enrollment has been maintained at all times.

Program Evaluation

A two-man research team is employed for independent evaluation of the program. Their efforts have included: (1) the collection of extensive data from each participant regarding background, training, current or past pastoral counseling experience, and expectations of the program; (2) direct observation of training sessions; (3) compilation of reports from instructors and co-instructors about each group experience and each participant; (4) examination of the participants at the end of the program; (5) prospective studies of pastoral counseling activity at the beginning and again at the end of the program; and (6) followup questionnaires to men who have completed the program. Results of the evaluation to date substantiate the extensive involvement of clergymen in mental health problems, the insufficiency of their training in this area, and the effectiveness of the program especially in terms of practical response. Results of the evaluation process have been helpful in influencing the development of the program.

This program has an excellent potential for replication in any setting where a mental health professional and a group of clergymen can arrange on some basis to meet regularly over an extended period of time.

The impact of the program in the religious community has been to stimulate concern for pastoral counseling and to improve its quality in the graduates, some of whom have also become active in community health efforts. In the psychiatric community there is now a greater interest in the work of the clergy. In Cleveland the program has served as a model for the continuing education of policemen and teachers in the mental health aspects of their work. This program marked the beginning of a focus on continuing education in the Department of Psychiatry of Case Western Reserve University School of Medicine.

The major strength of this project is that it reaches a large number of clergymen in an efficient manner which permits learning in depth. It is a relatively simple and flexible model which can be applied in a wide variety of settings. Its major weakness is the limitation in the degree to which staff can evaluate or respond to the strengths or weaknesses of the individual clergyman in his counseling work, since the program cannot provide individual supervision. The particularly innovative aspects of the program are its practical emphasis on the current counseling experience of the trainees in their everyday settings over an extended period of time, and the responsibility placed upon the trainees through the group discussions to determine their own role model in applying the material that is given to them.

A Clinical Mental Health Training Program for Clergy

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MH12090 1971–1976

Background and Objectives

The Clinical Mental Health Training Program is sponsored by Catholic Social Service, Inc., Diocese of La Crosse, Wisconsin in cooperation with the University of Wisconsin Extension. It is co-directed by Jacob Swidler, Ed.D. and Rev. Cornelius van der Poel, M.S. The program carries six and one-half continuing education units at the graduate level, University of Wisconsin Extension.

The program aims at developing an education model to help clergymen and other pastoral care workers find their place in the fields of mental health and human services. It aims at orienting professionals and community resources to the potential of clergy and pastoral care workers as allies in planning and delivery of community services. It will explore adaptation of the model to the training of other leadership groups. It is specifically designed for use in rural areas.

The program is based on four assumptions regarding the roles of the clergy and pastoral care workers ranked in the following order: (1) they are primary situation finders and case finders; (2) they are primary referral agents; (3) they have high potential to operate as social change agents in community planning and action; and (4) as counselors they are partners in the delivery of service. The program is designed to maximize performance of the students in these roles.

Methods and Content

The program is offered to the clergymen or pastoral care workers in their local area and on a part-time basis, so that there is no interruption of their ministry or assignment.

The program has an academic component that draws upon and integrates knowledge from the fields of social science and theology. This concept of integrating theology and the social sciences is preserved in all facets of the program through the team efforts of the co-directors, a layman and a clergyman. The lay director is a marriage counselor who has a doctoral degree; the clergyman, a recognized theologian and author, has a masters degree in pastoral counseling and is a practicing marriage counselor.

Major emphasis is on experiential group learning and supervised direct service experience aimed at accelerating and reinforcing learning. Experience indicates that because the students often have a sense of personal and professional isolation, attention must first be given to helping them identify, share and make decisions about themselves and their role as clergymen or pastoral care workers.

To provide personal consultation to students, representatives from various health and mental health agencies are utilized, providing an educational experience of direct contact with various professional and community resources. These persons are designated as clinical consultants. Nine clinical consultants are engaged for each class of eighteen students. They spend 64 hours in consultation with the two students assigned them and 40 hours in program development and in their own orientation to clergy training.

Major areas of course content are: integration of theology and psychology, personality development, trust, communication, self-concept, human sexuality, group process, and techniques and methods of counseling relationship.

The program is offered at various locations throughout the State of Wisconsin, some at points distant from the residence of the co-directors. A variety of time modules have been utilized including: ½ day a week for 16 weeks; 1-day and 2-day sessions extended over 12 weeks and utilizing the clinical consultation component for 14 weeks; eight ½-day periods and two 2-day periods extended over 12 weeks with clinical consultation extended over 14 weeks. In all structures the student receives a minimum of 32 hours of individual consultation from his clinical consultant. There is increasing evidence that a variety of time modules can be structured to accommodate this program to the needs of particular groups and areas.

Students

Eighteen students are enrolled in each offering of the program. The group is selected to include a cross-section of the denominations, of age groupings and of assignment. Extension of the program to include pastoral care workers makes possible a mixing of the sexes which has brought a new and positive dimension to the group.

There is a wide range of academic backgrounds in the student population, ranging from the bachelor degree level to completion of doctoral studies.

Program Evaluation

The program is now in its second year. From the outset, simple instruments were utilized to assess the students' growth. During the second year, a social researcher was engaged through the University of Wisconsin for 20 hours a month over a 6-month period. He has produced individual profiles and group profiles by use of the California Psychological Inventory and the Motivation Analysis Test. Results have corroborated assumptions which the directors formulated from their experiences and on which they had based program modifications.

During the next program year the researcher will assess the validity of the assumptions regarding the clergyman's role; he will test the conception of the clergyman's role as perceived by the clergyman, other professionals and consumers; he will assess the validity of the model for training other leadership groups; he will further test the validity of the teaching model.

Replication of the model should be possible in rural areas across the nation, wherever adequate community resources and professionals are available. At this time, the directors of the Clinical Mental Health Training Program for Clergy are beginning to explore a consortium to plan a program for the training of associate area directors and ancillary personnel for purposes of replicating the program in a broader geographic area.

To date, the program has at very least been coincident with a variety of developments in clergy training in the State of Wisconsin. The Wisconsin University Extension has originated a series of followup courses across the State. The Clinical Mental Health Training Program is an entry program for these courses. Students and directors have served as consultants in development of Extension programs. Several statewide associations are coordinating clergy training efforts. A network of communication between the groups and institutions engaged in clergy training has occurred.

The program receives community input from an 8-person advisory steering committee representative of all regions of the State of Wisconsin. This group represents the major statewide and regional organizations, departments or institutions engaged in planning or conducting continuing education courses for clergy.

Major changes that have occurred in the program since its inception are: (1) the concept regarding hierarchy of roles has changed, from counseling as a first priority (now fourth) to change agent, situation and case finder, and referral agent; (2) the experiential method has been increasingly emphasized; (3) concepts and techniques of communication theory and practice have been incorporated; (4) a new conception of the personality of the clergyman has been achieved; and (5) the student population has been extended to include pastoral care workers other than clergymen.

Continuing Education–Theology

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MH11436 1968–1973

Objectives

Confronted with increasing numbers of clergymen requesting continuing education, especially in mental health fields, members of the staff in the area of Pastoral Care at Christian Theological Seminary proposed to the President and the administrative staff that the seminary apply for a grant to set up a program for continuing education for clergymen in mental health related fields. Subsequently, the Professor of Pastoral Care drafted a proposal which was submitted to a group of supervisors of pastoral education in training centers related to Christian Theological Seminary. Their criticisms and recommendations were discussed in a plenary session of the group and were incorporated into a revised draft. This copy was then submitted to staff members of the Indiana State Department of Mental Health for their critique and counsel. At the same time, it was being evaluated by the administrative staff of the Marion County Comprehensive Community Health Center at General Hospital.

Specific objectives of the program are to: (1) cultivate health promoting goals, values and constructive social transactions in the minister's approach to the people in the community; (2) train clergymen in establishing appropriate goals and methods of counseling people in life crises, before they result in serious personal or family pathology; (3) give clergymen training in referral procedures and practices; (4) educate clergymen in psychodynamics so that they may engage in informed and relevant participation in rehabilitating people; (5)

develop the clergymen's potency and skill in mutual consultation with mental health professionals; and (6) help the clergyman develop his critical function in relation to groups in action in his community.

The objectives were readily endorsed and favorable support was given. Responses from members of these organizations were carefully considered as a final draft of the basic design of the project was made. The administrative staff of the seminary approved the application and submitted it to the National Institute of Mental Health. Subsequently it was funded for a 5-year period, 1968–1973.

Methods and Contact

The training methods used in the program include didactic sessions on psychodynamics and psychopathology, individual and group supervision of counseling and pastoral work, interpersonal groups, and field trips followed by discussion sessions.

The content of the training has been varied. Each workshop or training phase of the program has featured a different main theme. Workshops have been conducted on the following themes: The Role of Clergymen in Mental Health, Group Leadership, Aging and Dying, Sex and Family, Alcoholism, Drug Abuse, Psychodiagnostics, and Referral Techniques. Three 1- or 2-week workshops were conducted during the year.

One highly successful time sequence pattern of the training activities was the 1-day-per-week for 30 weeks program. The total of 240 hours of involvement in this 8/30 program (8 hours per week for 30 weeks) is the equivalent of a full load of courses for one academic semester (15 hours).

Another phase of the continuous program is counselor training. Interdisciplinary case conferences and individual supervision were provided for trainees on a 1-day-per-week basis for 36 weeks.

The Trainees

The 503 students in the program during the years 1968–1972 were clergymen. Most of the students (75 percent) have professional ministerial degrees. The average age of the participants was 40. They had spent an average of 14 years in the ministry, and had been out of seminary approximately 11 years. The numbers from the denominations represented are as follows: Methodist—128; Disciple—88; Church of God—18; United Church of Christ—12; Episcopalian—six; Christian Reformed—four; Church of Christ—three; Jewish—three; Independent—two; Holiness one; Free Methodist—one; Wesleyan Methodist—one; Not designated—five.

Program Evaluation

The program was evaluated in several different ways. The participants rated each aspect of the program on a five-point scale. Program content or presentation which received the lowest ratings were not repeated in subsequent planning. An inventory for assessing pastoral psychology attitudes was used to determine changes in the attitudes of the participants toward their pastoral work, especially in mental health related activities. Pre-and postcounseling tests were given to note changes in counseling effectiveness. A pastoral roles inventory was given for the purpose of seeing how compatible the clergyman and his role function were becoming. Personality changes of the participants were assessed through the use of the Minnesota Multiphasic Personality Inventory. Thus the staff was evaluating responses to the program by the participants as well as the effect of the program on the participants themselves, in both personal and professional functioning.

This program can be replicated at local, regional, and national levels. Affiliated relationships between pastoral training centers, community mental health centers, and seminaries throughout the country would make networks providing continuing education opportunities for clergymen who are potentially key people in community mental health.

The community, institutional, and organizational impacts of this project to date have been significant. Generally there is more interest in the mental health organizations of the communities represented. Several clergymen are already active in such organizations. One is the steering committee of a group planning a community mental health center in southwestern Indiana. Another is chairman of a mental retardation rehabilitation center. Still another is exploring the possibility of establishing a juvenile retreat and treatment center in northeast Indiana.

The training design was changed radically during the fifth year of the project.

The 1-day-per-week for 30 weeks time pattern worked well for the first few years. Then, as the number of clergymen who could conveniently schedule such hours per week diminished, a package of separate units was worked out to meet the needs of those who could devote only a brief block of time to continuing education during the year.

The major strengths of the project have been in the provision of intensive supervision and consultation for the clergyman in his work in his community. Most participants have acknowledged the strengthening of their personal and professional image and a greater self-awareness, which enhances their awareness of the real needs of the people in their communities.

Weaknesses of the program are chiefly in the area of lack of followup for reinforcement of the contracts which trainees make with their peers and supervisors. Also, there is the lack of multidisciplinary collaboration. Much of the consultation goes one way, from consultants of other disciplines to clergy trainees.

This program is innovative to continuing education in mental health because it involves clergymen with mental health professionals at decisionmaking levels. Thus it facilitates the communication process among clergymen and mental health professionals and enables workers in all the disciplines to appreciate the contributions of each other. They learn how to work together for the benefit of the total community.

A Program of Continuing Education for Psychologists

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MH12709 1971–1974

Background

The goal of the Oregon Psychologists' Professional Development Project is to create an ongoing program of continuing education for both psychologists and members of the related mental health professions in the State of Oregon. This program is sequenced in four phases: (1) a survey of professional interests and deficiencies for individual professionals, (2) organization of a network of continuing education organizations embracing the professional community, (3) facilitation of participant planning and execution of educational events to meet discovered interests and needs, and (4) evaluation of the effectiveness of the program. Each educational event (seminar series, workshops, conference) is planned by a group of professionals convened by project personnel because their survey responses revealed a common interest. Project personnel serve to facilitate the definition of the specific objectives desired; resource leadership is negotiated explicitly in terms of these objectives.

Methods and Content

Consonant with the program's participant-centered approach, the content area, the level and scope of treatment of that content, and the arrangement concerning time, total time devoted to the activity, and scheduling of time and place all vary from one event to the next. Among topics pursued have been application of behavior modification to a range of treatment settings and goals, Gestalt therapy techniques, family conjoint therapy, program evaluation, interest testing, cognitive functioning, and group dynamics. Programs have been offered in each geographical area of the State and with a range of formats and teaching methods.

The program attempts to ensure that the methods chosen to communicate the desired skills or information are well suited to the specific objectives of given educational events. Among the chosen learning formats are the following: (1) workshops, lasting from 1 to 5 days, (2) monthly meeting of practitioners for peer review, consultation and practice of technique, (3) series of 10 to 12 seminars surveying a defined range of content areas, (4) mini-seminars, organized individual study by participants culminated by a 1-day seminar critically evaluating the current status of a subject area, directed and led by a prominent figure in the area, (5) conference limited to invited participation by person with information or power to influence programs bearing on the topic problem area, (6) arrangement for professionals to work under supervision of a recognized expert in a given body of skills periodically over an extended period, and (7) distribution of the tape recordings of presentations made by visitors to the State.

Students

In the first 12 months in which programs were offered, total enrollment in the workshops and other events was 408. About 40 percent of these were psychologists. Roughly 50 percent were professionals from cognate areas, social workers, psychiatric nurses, educators, physicians, and psychiatrists. The remaining fraction (less than 10 percent) were paraprofessionals engaged in the delivery of psychological services: ministers, psychiatric aides, and volunteer counselors. Over time, participation has come from an increasingly broad band of disciplines among the intended target population, the mental health professionals in Oregon.

Program Evaluation

Since a primary objective is to involve as large a professional community as possible in identifying and pursuing continuing education for themselves, a primary datum for evaluation of success is part of such programs—both those offered through the project and other agencies.

A direct measure of the degree to which educational experience has increased the effectiveness of an individuals' delivery of psychological services is extraordinarily complex; a definition of knowledge required in all of the subspecialties, measurement of the mastery of that information, and measurement of the effectiveness of applying that information in the face of varying environmental settings present a formidable and costly task.

Indirect measurement is both feasible and meaningful by way of such indices as: (1) number of continuing educational opportunities available, (2) the degree to which these are attended, and (3) the degree to which professionals rate these events as having met their goals and increased their effectiveness.

A record of the program is to be published and should present no difficulty in replication in broad outline. A major impact of the project has been an increased awareness of community among professionals. Communication and interaction around professional development concerns have increased strikingly. These outcomes are those which have been sought by the program and thus have stayed very close to the original design.

The greatest strength of the program seems to lie in its reactive nature. Individual professionals have been involved as active and voluntary participants in this educational enterprise.

The major weakness of the program is the excessive amount of time needed to move from the original concept to the educational event. Time and effort are required to convene groups, to involve relatively large numbers in planning.

Training for Clergy Caretakers

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MH11807 1969–1974

Background and Objectives

This is a nonprofit organization based in Seattle and founded in 1968 by an ecumenical group of pastors, church leaders, and concerned clinicians. Its aim is to assist clergymen in developing and perfecting their function as ministers in a changing world through integration of the pastoral with the psychological and social sciences.

The Institute provides the clergyman, his family, and in certain instances his key lay leadership, with four major services: (1) continuing education and training for the human relations helping process, (2) career-development evaluation and guidance, (3) counseling for the clergyman himself and his family, and (4) consultation on his pastoral work, especially on those aspects where a mental health specialist may be of assistance. Two adjunctive services are: (5) program service and resource to denominational leaders, and (6) consultation in organizational development.

Specific objectives include the development of greater skill in recognizing and handling personality disturbances in those who come to the pastor, and greater sophistication in referring to and cooperating with clinicians; greater awareness of the changing social context of the ministry, and perceptiveness of the group dynamics at work among his parishioners; assessment of present strengths and weaknesses in himself with a view toward updating his training or perhaps retooling for a new type of ministry; and support for the clergyman who finds difficulty either in pursuing his calling or in coping with the rapid changes of society.

Methods and Content

Training programs include: regularly scheduled seminars in the wide range of pastoral concerns; special laboratories in human relations, conflict management, handling social problems, and other critical issues of the day; training courses to help the minister work with a total range of counseling problems such as marriage, alcholism, adolescence, family relations, personal crises and grief work; and special tailor-made workshops, training a clergy task force in meeting mental health needs in a given geographic area. The seminars and courses usually meet 2 hours a week for 8 consecutive weeks under an instructor who typically has the doctoral degree; other activities are for the shorter periods and may involve living-in or intensive sessions, often under nationally-known leaders. Content ranges from needed information about his community and its mental health resources and problems, through specific counseling skills in dealing with both individuals and groups, to material which will enhance the clergymen's own sense of professional identity.

This program is planned by the Director of Training and a curriculum committee which includes a clinical psychologist, a pastor, a university professor-priest, a clergy member of a campus ministry team, and a student in the Pastoral Institute. The curriculum committee is appointed by the Board of Directors and is advisory to the Director of Training.

Students

A "Certificate of Advanced Pastoral Studies" is granted to those who complete a minimum of 96 classroom hours in a combination of courses, seminars, workshops and conferences planned by the Director of Training for the needs of the individual minister with an eye to such standard-setting organizations as the American Association of Pastoral Counselors. During the past year 97 students from 14 different denominations participated in regular courses, 320 enrolled in shorter conferences and workshops, and more than 1,500 took part in special training for denominational and ecumenical groups of clergy. There were 18 candidates for the Certificate of Advanced Pastoral Studies, and 94 persons were seen by the professional pastoral counselors at the Institute for some type of therapy and another 16 were referred to other professionals in the community. A staff of six consultants is maintained in the areas of psychiatry, clinical psychology, social work, and social change. Fourteen clergymen underwent career evaluation. Nearly 2,900 persons have been served by the Pastoral Institute during its first 3 years of existence. Since it is the only facility of this kind for pastoral training north of Berkeley, the potential number of users in the Pacific Northwest area is well over 10,000 and may extend to Alaska as well as Washington, Idaho, Oregon and Montana.

Program Evaluation

Program evaluation takes place at various levels. The Board of Directors, a broadly based group representing the supporting denominations and cooperating clinical professions as well as many colleges and universities in the area, sets general policy and reviews program activities through its curriculum committee and its personnel committee. The curriculum committee meets regularly to evaluate course offerings. The Director of Training requires a written and oral evaluation of his program from each candidate for the Certificate of Advanced Pastoral Studies, which is relayed to the curriculum committee for use in future planning.

As a result of these processes a greater stress has been put on professional identity and career evaluation, on the changing social context of the ministry, and on the need for a greater therapeutic support system within the church structure as well as within the Institute because of the mental health stresses to which clergymen are subjected today.

The program is not only unique to the Pacific Northwest but signalizes a remarkable integration of spiritual with psychological approaches and a high degree of cooperation between various professions and religious groups. Most of its characteristics could be imitated elsewhere, but probably an equal amount of planning would be needed to tailor the program to the interests and personnel of the area and involve similar interprofessional cooperation.

Continuing Education for School Personnel

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MH11828 1969–1973

Objectives

The general objective of this program has been to impart psychoanalytic understanding to educators who may thereby become enriched in their knowledge of dynamics of child growth and development, specifically to the task of learning and teaching. The specific objective in this grant-supported program has been to take the general objective into a specific school system, i.e., the Culver City Unified School District, and to test whether it has any impact or capacity to change the educators and the system within which they are functioning. The trainee target groups are the teachers in the classrooms, the principals of the schools and the various other related disciplines to be found in the schools.

Methods and Content

For 4 years the format followed has been a semi-formal didactic experience for a class composed of two-three faculties of elementary schools in Culver City. This 2-hour session was conducted in late afternoon in one of the elementary schools. The course ran 12 weeks, beginning in late September. One instructor from Reiss-Davis would be used for the entire course. The project director would meet periodically with principals and/or administrators in a liaison function, providing significant information and interpretation of course material being presented to the teachers. In addition he would obtain and react to the principal's feedback data. In early spring the second course began and the format was to divide the original group into two smaller classes, each one of which was led by another Reiss-Davis staff member. (Neither of these had served as instructor in the fall.) The project director again arranged for periodic meetings with the principals for the same purpose outlined above.

The specific content area in the first fall session was psychoanalytic understanding of factors and influences on the act of learning and teaching. Entitled, "The Learning Process," the course drew heavily on the epigenetic scheme of Erikson, and stages of emotional development described by Freud. These were organized and presented to the teachers with special emphasis on their contributions to learning. In each succeeding fall semester the informal didactic presentations have included the following: "The Development of a Professional Identity in the Teacher-Issues Related to Role and Function Within the Educational System"; "Conferences Held with Parents" and currently (fall 1972) "Parent-Teacher Interaction." In each spring semester, the group was again divided into two smaller groups, led in discussion by a Reiss-Davis staff member. The project director continued to hold appointments with the principals as already described.

The time sequence as stated was 2 hours per class session for 12 consecutive weeks. The site was a school where teachers worked and the course held in late afternoon. These have been offered each fall and each spring since the project started.

Students

The trainees in this program are graduates of schools of education with teaching credentials. They are presently working as teachers in elementary school classrooms. There have been 30–35 in each class. The participants' level of prior training is a B.A. or B.S. in education with quite a few having completed the Master's Degree in Education. Some of the principals have their doctorates. Potential trainees are the other teachers in the school system who have not yet been able to enroll in these courses. This is especially true of the Jr. and Sr. High School faculty and the staff is interested in establishing a comparable project for them.

Program Evaluation

The method used for evaluation has been described by Dr. Christoph Heinicke, Director of Research at Reiss-Davis. His statement on page 39, Reiss-Davis Clinic Bulletin, Vol. 9, No. 1, Spring 1972, is as follows: "Various forms of assessments have been developed to capture the teacher's feeling and functioning. One assessment was based on the teacher's own evaluation of the experience, a second relied on the judgments of the principal, and a third made use of the observations of the consultant. At the end of each part of the consultation sequence so far (December 1969, May 1970, December 1970), each teacher was asked to respond to the following three questions: (1) What did you get out of the experience; (2) What would you like to see changed in the way the material is presented or discussed; and (3) What other approaches would you like to see stressed as we plan for the next sequence? The responses were such that it was most meaningful to have a rater judge the extent of positive impact of experience and the degree of satisfaction with it. Another way the dimension was defined was that the teacher experienced it as meaningful and positive and did not desire any drastic changes. The answers to all of the three assessment points were used to arrive at one rating. After the ratings were done the total sample of teachers was rank-ordered in terms of the dimension of experiencing a positive impact.

"A second assessment involved the evaluation made routine by the principal at the end of the school year. These were reviewed and recorded in interviews with the principal held shortly after the beginning and end of the time interval being considered (September 1969 and December 1970). The evaluation covers nine areas of teaching functioning, ranging from instruction skills to teacher-staff relations. Each area is carefully defined in a manual provided by the school system. Raters were asked whether any change (positive, negative, or non) could be detected in the before and after description in each area. The total evaluation was carefully studied in making the separate judgments. A score of 9 signified that the teacher progressed in each of the areas. These scores could again be ranked for the total sample. A third assessment was made by us on the basis of the extensive process notes which we dictated after each session. The process notes of the other consultants were also read. The degree of impact was rated in terms of a nine-point scale ranging from −1 to 7. Any type of impact of the group consultation significant for that particular teacher was considered. The basis of the rating was then carefully described in a paragraph. The ratings can again be put in rank-form ranging from most to least impact as judged by the consultant."

The potential for replication of this program is very good. The institutional or organizational impacts of this project are best understood in the words of Dr. Anita Mitchell, Director of Pupil Personnel at Culver City Schools. She presented these observations in her role as discussant of the project's work at a meeting of the American Orthopsychiatric Association: "The results were more than we bargained for and we have realized many gains beyond the original objectives: (1) You can't take a child out of the environment, change him and toss him back into the same environment. This program is helping to change the environment. Courses given at Reiss-Davis Child Study Center were aimed at the same results, but few teachers were able to implement. (2) There were two particular elementary schools chosen because of stability of pupils and staff. Some teachers had reached a plateau of performance and we had not exhausted our repertoire of techniques for changing them, and teachers formerly 'set in their ways' are now demonstrating new interests, vigor, and change. (3) It is simpler, more comfortable, less threatening to use the consultants for direct advice in handling problems. Growth is manifested in movement toward a more vulnerable stance—accepting responsibility for growth in self and pupils. (4) Teachers who had been at the school for more than 15 years were able to handle reassignment to other schools without damage to themselves or others as a result of the consultation process. (5) Teachers are manifesting changes to grading patterns, referrals to Pupil Personnel, attendance of pupils, etc. (6) After 1½ years of consultation, the faculty was able to handle a change in principals, even though a similar change attempted 1½ years ago caused considerable reaction. (7) There is an increased ability to describe pupil behavior in precise terms. Teachers have learned to report more objectively because they realize their colleagues will recognize their lack of precision. This positively alters their perceptions of the situation and changes their attitudes. (8) The pupil personnel staff has changed; staff members see the teacher rather than themselves as a primary helper. They see themselves as managers, rather than dispensers, of pupil services. (9) Management has changed—I've changed—particularly in my perception of old colleagues' ability to change. I am accepting responsibility for that change. (10) Teachers have been made to feel comfortable with failing to reach a sick child. This has far reaching effects. Consultants reach teachers whose professional performance and professional competence influence 30 or more families annually. (11) Consultants have changed. They are aware of the problems of the schools and of teachers' creative approaches to handling problems."

The major strengths of this project have been (1) the structure (worked out in joint planning with the school personnel); (2) the abilities and sensitivities of the instructors; (3) the capacity of flexibility on all sides so that content could be dropped as more urgent issues emerged; (4) the continuity, i.e., the use of same Reiss-Davis personnel over an extended period. The weakness has been in the project's inability to cover all school faculties at the same time. This would have required much larger resources, both in manpower and funds.

Crisis Telephone Services on Campus

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MH12592 1971–1973

Objectives

The general objectives of this program have been to increase the effectiveness of college personnel in dealing with mental health problems of college students from various racial, ethnic and socioeconomic backgrounds; and to provide college and university personnel with the knowledge and skills necessary to organize, implement and improve crisis calling centers for students.

Specific objectives have been to assist college personnel in understanding the dynamics of the "student in crisis" and in developing effective procedures for establishing and improving crisis telephone services on campus, such as in recruiting of volunteers to staff the service, locating and securing cooperation of "helping resources" available at the college and in the community, use of techniques for training volunteers (role-playing, empathy and listening exercises, simulation games, tape evaluation, orientation methods, etc.) and evaluating program effectiveness.

Methods and Content

Training methods used in the first summer workshop (August '71) included empathy training and listening exercises, role-playing, use of a simulation game to sensitize participants to needs of persons from lower socioeconomic backgrounds, listening to training tapes, viewing training films, visiting "helping resource agencies" in the community, and conducting workshops focusing on specific topics (i.e., basic considerations in establishing a campus crisis calling center, handling drug abuse calls, problems of the "woman in crisis," etc.).

Specific content areas included: problems of minority group students, the woman in crisis, handling suicide calls, handling drug calls, locating "helping resources" in the college and general communities, techniques used in training of volunteers for crisis telephone service, and how a campus goes about establishing a crisis telephone service.

The first summer training workshop entailed 2 weeks of training activities, totaling 71 course hours. Specific activities and blocks of time were: listening exercises, empathy training, role-playing—10 hours, sensitizing personnel to problems of minority group members—4 hours, training tapes and films—8 hours, resource agency visitations—8 hours, workshops on special problem areas in crisis intervention (i.e., drug abuse, woman in crisis, problems of evaluating service effectiveness, etc.)—15 hours, workshops on establishing crisis telephone services and improving already-existing services; exchange of ideas, methodology, etc.—15 hours, presentations by guest speakers—6 hours, and feedback sessions from participants—5 hours.

Students

The disciplines represented by participants attending the workshop, and the number of participants in each discipline were psychology—29, nursing—1, college administration—4, ministry—1, and humanities—5.

The population of potential trainees consisted of college personnel and/or students indicating an interest in establishing and/or improving crisis telephone services on their respective campuses. Participants selected included: two directors of counseling services, two directors of crisis lines, 13 crisis line undergraduate paraprofessionals, five graduate students in psychology, one chairperson, department of psychology, 21 undergraduate students (including paraprofessionals), and 14 professionals (including college administrators, psychologists, public health personnel, ministers, counselors, etc.).

Twenty different colleges were represented at the summer workshop. Of these, seven did not have an existing crisis telephone service. Of the seven, three have since established a service and planning is underway at two others.

No single evaluation method was employed by program staff. During the summer workshop, provisions were made for continual participant feedback and changes were then made as determined by the needs of participant institutions. Continuous telephone and mail contacts were maintained with participant institutions not having existing crisis telephone services, in order to offer assistance and guidance. Five of those seven institutions either have instituted a crisis telephone service or are in the planning stages. Questionnaires were sent to all participants, but the return rate was low. During the followup phase of the program, which continued in the months after the summer workshop, resource check-lists of materials were made available. Approximately 30 check-lists were returned, requesting from one to 12 items on the list. In addition, telephone contact was made with many of the participant institutions to determine their needs and how the program could meet those needs.

Program staff and personnel concur that the potential for replication of this program on regional and national levels is high. One unique aspect of this particular program is that it limited itself to *campus* crisis hotlines. It would be difficult for the program to encompass a larger population, but a similar program intended to assist community crisis hotlines would benefit the entire field of crisis intervention. Program staff is also in agreement that limitation of this program to campus hotlines is necessary since campus populations frequently reflect much different needs than a total community population would.

This program has, since its inception, attempted to help organize regional crisis intervention workshops. It is in contact with campus hotline personnel in other States, who are interested in pursuing such an undertaking.

Program staff and personnel have noted the following impacts of the project to date:

1. College courses in crisis intervention have been instituted at Southern Colorado State College and Southern Utah State College since the summer workshop. In both cases, the courses were developed by participants in the Crisis Telephone Services on Campus Training Program.
2. Program staff developed a psychology course in "Woman in Crisis" which is now offered at Southern Colorado State College.
3. Several participant institutions have reported cooperation with various community agencies in developing "Rumor Control Hotlines." One such line was instituted at Southern Colorado State College.
4. Program personnel designed a presentation which was given to the Rocky Mountain Psychological Association at its annual meeting in 1972. Another such presentation is scheduled for the RMPA meeting for 1973.
5. In Pueblo, Colorado, the program has been able to facilitate better communication and cooperation with local mental health centers and various crisis intervention agencies.

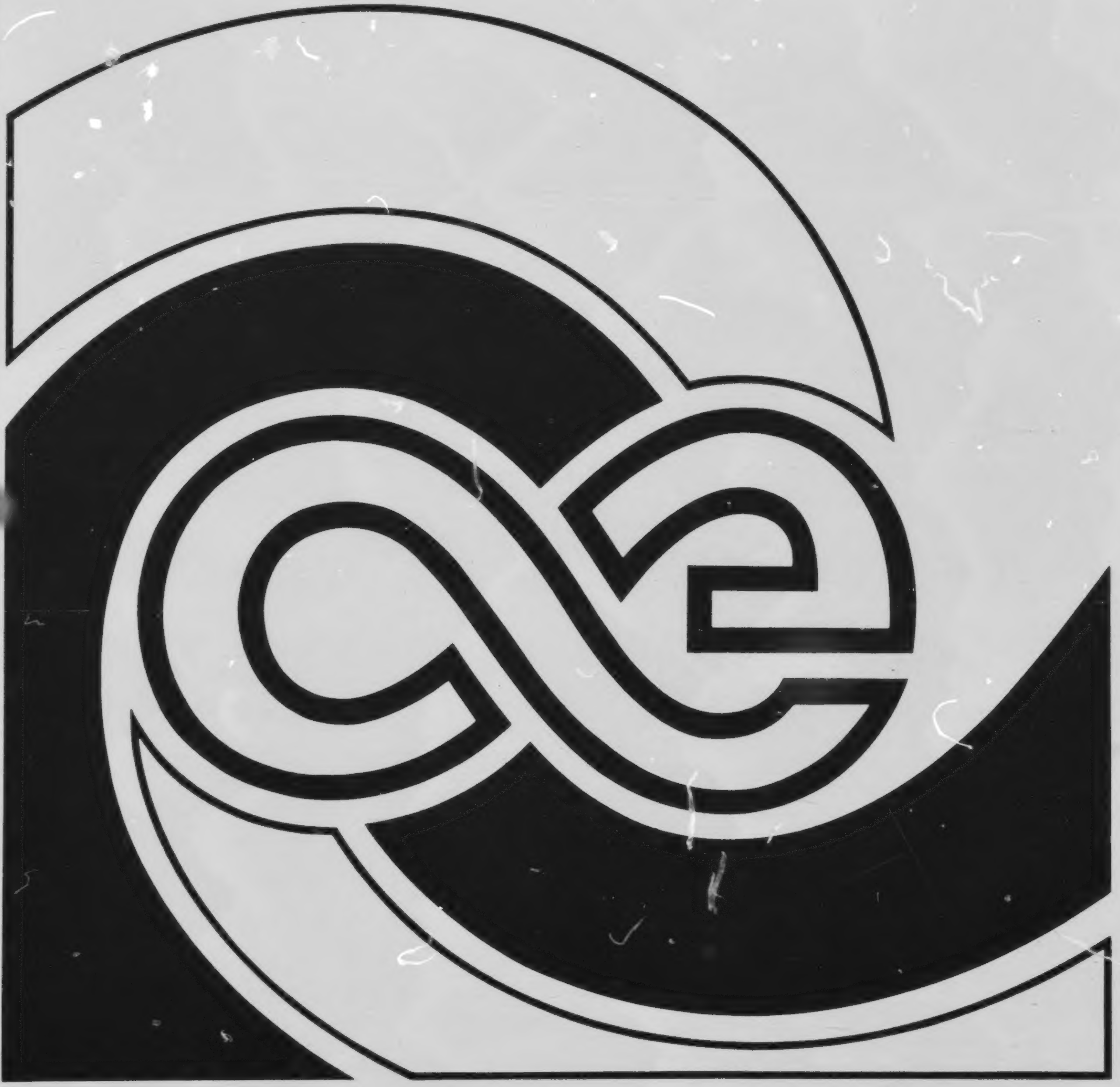
The program will continue until March 1973, and will co-sponsor, with the American Institutes for Research in Kensington, Md., a working seminar in February for researchers who are presently developing instruments and techniques for evaluation of help-by-telephone services. This effort is being undertaken in response to numerous requests for assistance in the area of evaluating the effectiveness of crisis telephone services. Proceedings of the seminar will be published and made available to interested agencies. In addition, information presented at the seminar will be utilized in the proposed summer workshop for the Crisis Telephone Services on Campus Training Program. At the workshop, participants will receive training in utilizing evaluative instruments and techniques.

The major strengths of the program are its identification as a major clearing-house of information and materials on crisis intervention and its service in facilitating via newsletter and other campuses. Enthusiastic response to summer workshops for campus personnel and students interested and involved in help-by-telephone services indicates that the program has been meeting an important need. The program has the resources to make site visits to institutions requesting assistance in setting up the operation of a crisis telephone service.

A major weakness of the program is its lack of sophisticated evaluative instruments and techniques, but steps have been taken to correct this deficiency. Also, the summer training workshop in 1971 did not devote adequate time to the area of crisis intervention for members of minority groups, but again, steps have been taken to correct this.

PART 4

CONTINUING EDUCATION FOR NURSES AND RELATED PERSONNEL



State Nursing Plan for Mental Health

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MH12963 1972–1975

Objectives

The general objective of the State Nursing Plan for Mental Health is the development of formalized and continuing education programs for registered nurses, nursing personnel and citizens, designed to: (1) provide up-to-date knowledge concerning mental health; (2) demonstrate approved patient care techniques to improve the skills of registered nurses and other nursing personnel; (3) emphasize potential patient improvement resulting from positive rehabilitation care concepts; and (4) emphasize potential patient improvement resulting from changed attitudes of citizens toward local, State and National resources. A system of delivery will be developed for the programs designed to reach 90 registered nurses, 1,050 nursing personnel, and 700 citizens.

The program also will provide supportive services to agencies and organizations involved in Project I, Registered Nurses; Project II, Nursing Personnel; and Project III, Citizens. These projects will be initiated through planning meetings of program staff with local advisory committees which will identify mental health needs and decide areas to be covered in workshops. An organized sequence of workshop content and procedures will be developed and distributed to practicipants and agencies.

Methods and Content

Arrangements are made for the site, subject, faculty, publicity and coordination of other teaching programs and organizations. In Project I, Registered Nurses, the total number of workshop days for the first year is 36. The nurses are divided into three groups of 30 each. Each group's course hours total 96 the first year. For the second year, the total number of workshop days is 27, with each group's course hours totaling 72. The third year, workshop days total 18, with a total of 48 course hours for each group. Project II, Nursing Personnel, provides for workshops on a State-wide basis, divided into seven districts. The total course hours for Project II is 16 hours per district, or a total of 112 hours the first year and the same for the second and third years. Project III, Citizens, also provides for workshops on a State-wide basis, divided into seven districts, with 8 course hours per district, or a total of 56 hours in the first year and the same for the second and third years.

Students

Project I, Registered Nurses, was planned for 90 registered nurses, but at present 111 have enrolled. The central Arkansas area program has not started, but it expects to hold to the 30 nurses planned, so that a total of 141 registered nurses would be involved.

Program Evaluation

The development of the continuing education programs will be evaluated through program content and the delivery of the program will be evaluated through tabulation of the number of agencies reached, agency attendance based upon area of coverage, and citizen participation. Results of testings developed to evaluate the content as presented at each workshop will be analyzed. Questionnaires distributed to participants will seek subjective data, describing individual opinions as to new knowledges and skills gained.

Supportive services to agencies will be evaluated through selected visits to agencies to survey implementation of workshop content; display and distribution of workshop proceedings; and comparison of data collected at initial planning meetings with the data collected at the end of each workshop.

The unique aspect of this program is that final decisions for specific content to be presented are made by local advisory committees with the ALN Staff and principal instructor. This is the organization's philosophy and is a mandatory procedure for any workshop for which it accepts responsibility. Its role in meetings is to listen, clarify statements, ask questions, summarize what has been said, and be sure that it is understood why the need identified is important to the community and what can be presented in the workshop that may bring about change.

The major strength of the program is the blueprint of the three projects—the individuality of each project and cohesiveness of the three projects together.

Continuing Education–Nursing

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MH11378 1969–1974

Objectives

The general objectives of this program are to provide continuing education programs which will aid nurses and related health professionals to improve the quality and quantity of health care delivery. The specific objectives are to provide both clinical and theoretical skills in psychiatric and mental health nursing for registered professional nurses who did not receive this preparation in their nursing program; and to update clinical and theoretical skills of registered professional nurses who received this preparation in their nursing program. This course is designed to: (1) increase the student's knowledge of psychiatric mental health concepts, varieties of treatment methods, and the availability of community resources; (2) increase the student's awareness of her own strengths and limitations in working with patients and their families; and (3) provide the student with an opportunity to develop additional skills in assessing disturbed communication between herself and another person and to develop new skills in intervention to correct or modify the disturbed communication.

Methods and Content

A problem-solving teaching approach was emphasized rather than the straight lecture method. A variety of training methods were utilized. They included:

(1) seminars and lecturettes focusing on a specific content area for discussion;
(2) simulated interactions emphasizing role-playing of selected problematic behavior with the goal of practicing and learning effective nursing approaches to these behaviors;
(3) a communication laboratory providing skill practice in selected therapeutic communication and application of group dynamics;
(4) field observations of mental health agencies in the student's own community;
(5) films;
(6) guest lecturers to acquaint students with new developments in mental health; and
(7) clinical application of theoretical knowledge with supervision.

The focus was on the feelings and behavior of patients and the nurse in the nurse-patient relationship; developing more effective communication skills in modifying problem behavior; identifying and applying mental health concepts from the literature to patient care in varied nursing settings; exploring community resources and modes of treatment in mental health; and increasing self-awareness and constructive participation in group interaction.

Examples of specific content areas focused on were: myths and fallacies regarding mental health and mental illness, comparison and contrast of selected psychiatric theories and approaches, principles of the nurse-patient relationship, communication theory, behavior and defense mechanisms exhibited by patients in distress, drug and alcohol abuse, and additional treatment modalities, that is, electroconvulsive therapy, chemotherapy, and milieu therapy.

This course offers five units of University Extension Credit. The class meets for five 1-hour class sessions per week for 12 weeks, a total of 60 course hours. During the 12-week session, the students have 24 hours of clinical supervision, 12 hours of agency observation, 18 hours of communication laboratory, and 36 hours of lecturettes and seminar discussion.

Students

The students in the program are registered nurses who wish to increase their effectiveness in their work roles by applying current mental health concepts to patient care and nurses who did not receive basic psychiatric nursing in their basic nursing program. The course meets the requirements of the Board of Nursing Education and Nurse Registration of the State of California.

This course is in demand by nurses from numerous foreign countries who wish to practice nursing in California. For example, in 1 year, nurses from 17 foreign countries were represented in the student population. Educational preparation ranges from diploma to Associate Degree to those who need the course for entry into Master's level work.

Program Evaluation

The methods used for evaluation of the course include student and teacher evaluation. Upon successful completion of the course, students are eligible to write the State Board Examination for licensure.

Instructors of this course face a challenge in working with students from many different countries and cultures whose basic language is not English. Applicants are screened for written and spoken language abilities. To some extent, the instructors feel the language barrier can be surmounted by use of audiovisual material followed by discussion to present the more complex mental health concepts. Student evaluations of the course are predominantly positive in that the course provides an opportunity to apply the knowledge learned to practice.

Because many of the nurses in this course have come from foreign countries and, in many cases have returned, it has been virtually impossible to utilize long-term evaluations to determine how they see themselves applying the knowledge and skills learned 1 or 2 years after completion of the course.

Some of the foreign students go on to complete Master's level work in psychiatric nursing and return to their own country to develop nursing programs which include mental health content. Many others seek positions in nonpsychiatric settings and utilize what they have learned in these setting.

The importance of this program is that it provides registered professional nurses with an opportunity to become aware of the newest developments in psychiatric/mental health nursing; that is, it focuses on a community-based approach to mental health care.

In the future, the program plans to incorporate this course into a comprehensive psychiatric/mental health continuing education curriculum which will offer basic, intermediate, and advanced courses where practitioners can update and add to their skills and effect in the delivery of mental health services. This curriculum will be available to nurses in Northern California.

Continuing Education–Nursing

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MH11518 1969–1974

Objectives

The general objective of this program is to provide continuing education programs which will aid nurses and related health professionals to improve the quality and quantity of health care delivery. The specific objectives are to improve the practice of professional nurses and related health workers in State and Federal psychiatric hospitals, psychiatric units of general hospitals, and community mental health centers. The objectives are behaviorally stated and developed by the students and the instructors in three categories: (1) self-development; (2) clinical development; and (3) theoretical development.

Methods and Content

The course provides the students with an opportunity to define their own objectives and work with the faculty to meet their own objectives. Each student designs a clinical project for application in her own work setting and seeks out supervisor-preceptors within her work setting to enable her to continue the project after the course is completed. Unemployed students include agency negotiation in their clinical project. Resource persons, bibliographies, clinical supervision, seminar topics, films, and other training methods essential to the students' needs are planned and developed by the students and the faculty. The faculty assists students to delineate content which they feel is essential to their learning. Topics which have been utilized are patient assessment, evaluation, death and dying, crisis intervention, specific psychotherapeutic treatment approaches such as Gestalt therapy and community mental health.

The course offers 12 university extension credits. It meets 2 days a week, 3 hours a day for 10 weeks for a total of 160 hours. The course meets 2 days a week to accommodate those nurses who are employed.

Students

This course has been subscribed to by registered professional nurses in State and Federal psychiatric hospitals, community health centers and general hospitals. Their educational preparation has been varied. All have basic psychiatric nursing preparation and many have master's level preparation.

In California, the State hospitals are being decreasingly used for treatment, and mental health services are provided by many agencies within the community. Therefore, there is an increased demand for this course from students in general hospitals and community mental health service settings.

Program Evaluation

The course is evaluated by students and faculty. The student works with her instructor to determine whether or not the objectives mutually agreed upon have been achieved. In this course, evaluation is a continuing process.

In the beginning, the students have difficulty in defining their own learning needs. However, when the instructors act as facilitators and help the students define their priorities, it is found that the learning that occurs is greatly enhanced.

Since each student designs a clincial project which has relevance to her work setting, transfer of learning as well as direct application of knowledge and skills in the work setting occurs. For example, some students have begun co-leading groups in their work setting while others have taught crisis intervention skills to their colleagues in the emergency room setting. Therefore, the program has some evidence of a spread effect.

The major need in evaluation of this course is to determine in what way the students are functioning differently 6 months to 1 year after completion of the course. It would also be important to know whether or not additional continuing education is sought and what impact this education had on the students' own delivery of health care. The students come from many parts of the nation and followup is, therefore, complicated. To date, the program has not been able to accomplish followup evaluations on students, but this may be a need in the future.

There are plans to incorporate this course into a comprehensive psychiatric/mental health continuing education curriculum which will provide mental health professionals with the opportunity to pursue basic, intermediate, and advanced courses. It is believed that development of a broader curriculum will provide the mental health practitioner an opportunity to update skills and to seek depth in her particular area of theoretical and clinical expertise.

Continuing Education—Nursing

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MH11519 1968–1973

Objectives

The general objective of this program is to provide continuing education programs which will aid nurses and related health professionals to improve the quality and quantity of health care delivery. The specific objectives are to identify, explore, and demonstrate, through experiential learning, approaches to teaching psychiatric nursing concepts. The largest trainee group consists of teachers of nursing in programs of nursing throughout the United States.

Methods and Content

The training methods utilized encouraged the students to take an active and interested role in their learning. It provided the students with models of teachers as warm, knowledgable facilitators rather than an image of omniscient authority. The emphasis was on developing the student's ability to teach and include psychiatric nursing concepts in her home school's curriculum.

A variety of training methods were utilized to assist the student. They were seminars, role playing, group exploration, and definition of content areas (with instructors facilitating group identification of the process of defining content), awareness group (with focus on observation and analysis of individual, interpersonal and group dynamics), "T"-group, micro-counseling laboratory, clinical supervision, field trips, team teaching, films, group sharing of resource materials, and the use of videotape experience in teaching and learning.

The specific content of the course was primarily decided upon and developed by the participants with the instructors acting as facilitators. Some examples of content included were: Mental Health Concepts, Community Mental Health, Family Therapy, Group Dynamics, Integration of Psychiatric Nursing Content and Trends in Nursing Education.

Upon successful completion of the course, the student received nine university extension credits. Course hours totaled 265. Students met for 6 weeks from 8:30 to 5:00 p.m., Monday through Friday. Clinical assignments averaged 2 hours per week with 2-hour small group seminars after each clinical session. On a weekly basis there was a sharing of resource materials, a 3-hour awareness group, a 2-hour small group for experiencing and studying group dynamics, teaching presentations to the total group, seminars with guest speakers, and four 2-hour microcounseling laboratories.

Students

The students were instructors of nursing programs (Licensed Practical, Diploma, Associate Degree and Baccalaureate Programs) with varied levels of educational preparation (Baccalaureate to Master's Level). They represented programs of nursing throughout the Nation.

Program Evaluation

Two methods were utilized to formally evaluate the program. The students submitted a written self-evaluation of their own learning. In addition, students evaluated the total program, that is the instructors and the course itself. These evaluations revealed both positive and negative aspects. The students felt that the course organization and content were pertinent to the individual's learning experiences and future needs and that the teaching methods served as motivational factors toward role model development. Negative aspects included a need for more focus on integration within different levels of nursing programs.

This program was utilized by teachers from nursing programs located throughout the United States and provided the teachers with added skills by which they could integrate psychiatric nursing concepts into nursing curricula and ultimately affect, in a positive direction, the delivery of mental health services to the consumer of nursing care.

A major weakness can be identified in that no long-term followup evaluations were utilized to determine how much of what had been learned was actually being implemented in nursing curricula. Part of the reason for not determining this effect was due to the mobility of the students involved.

This program will continue to be offered to instructors of nursing, and the offering of this course will be expanded to include health professionals in psychiatric as well as non-psychiatric settings. This emphasis is needed because of recent mental health legislation in California whereby many persons are being discharged from State psychiatric facilities to their own communities. Besides being a part of the local mental health program, these persons are also utilizing the communities' general health services. Since the personnel of the local communities are often unprepared to deal adequately with the psychosocial components of care, it is felt this program should be continued to help prepare those health professionals, for example in-service educators, who are in need of the content.

The course also will be incorporated into a comprehensive psychiatric mental health continuing education curriculum which will offer basic, intermediate and advanced courses. This will provide mental health professionals an opportunity to update and add to their skills in their particular area of expertise.

Comprehensive Multi-Level Training Program in Continuing Education

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MH12830 1972–1974

Objectives

The general objective of this training program is to develop a continuing education program designed to improve the quality of total health care, by enhancing the capabilities of multi-level personnel (e.g., registered nurses, licensed vocational nurses, psychiatric technicians, nurses aides, and administrative personnel) employed in nursing and convalescent homes, and long-term care facilities.

The specific objectives are to prepare individuals within these several nursing care categories to work with the emotional and psychological aspects of general patient care and with the mentally ill. The individuals enrolled in the program will be prepared to function in the following ways: (1) professional and practical nurses and psychiatric technicians will be trained to plan, develop, and implement patient care; to direct, supervise and train nonprofessional personnel in more efficient and effective ways; and to seek and secure necessary and appropriate consultation from medicine, nursing, social welfare, and other community resources; and (2) nurses aides and related workers will receive training in elementary psychiatric-mental health understandings and skills necessary for the emotional care of their long-term patients.

Methods and Content

The training methods used are lectures, discussions, clinical supervision and consultation, readings, and action-oriented methods (e.g., role-playing, etc.), videotapes, and films.

Content areas include: mental health problems of the aged; treatment modalities; psychological aspects of institutional life; management of acute psychiatric situations and patient emergencies; interrelationship of health workers in the treatment program; the use of consultation and community resources; methods of planning and coordinating for effective patient care; and death, grief, and mourning.

The program plan consists of three phases: (1) assessment phase—at least 15 hours to assess and evaluate the needs of the nursing home and staff; (2) 60 hours of training during an 8-week period; (3) a followup program of evaluation and further consultation for 1 day a month for 4 months.

Students

Plans are to reach 3,250 multi-level nursing personnel, over the 4-year period, employed in nursing homes and related agencies, mental health centers, general and psychiatric hospitals. Priorities have been determined as follows: (1) multi-level nursing personnel in nursing homes and convalescent hospitals; (2) nursing personnel specialized in mental health care delivery setting; (3) nursing personnel specialized in general health centers; and (4) participation in multi-disciplinary planning for multidisciplinary needs. Trainees will be given extension credit and certificates of completion.

Program Evaluation

Student evaluation will take place on several levels: (1) attendance and participation; (2) pre- and post-test of course material; (3) observation by faculty of clinical application of course material by students; (4) pre- and post-attitude tests; and (5) a written evaluation by each student of the course, its content and methods of presentation, and of the faculty.

The strength of the program is in its innovative approach to continuing education, which involves multi-level personnel as students and as faculty, and brings the program to the health facility (community based).

BEST COPY AVAILABLE

Mental Health Workshops for Administrative Personnel

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MH11785 1969–1974

Objectives

The purpose of this project is to provide opportunity for a selected group of management and staff personnel of educational, health, and welfare agencies to deepen their knowledge of psychological development and mental health principles and to increase their skill and understanding of relationships with people with particular application to the participants' professional roles.

Methods and Content

The training methods used in this program include lectures, films, field trips, and discussions. Content areas include psychological development, mental health principles, and application to specific problems presented by participants, e.g., problems of children and adolescents, persons in crisis, terminal illness, death, and dying. The program consists of approximately 36–40 contact hours plus assigned readings and experiential assignments.

Students

Participants in the program include social workers, hospital administrators, nurses, teachers (elementary, secondary, college), ministers, counsellors, child welfare workers, and students majoring in education, psychology, nursing, and social welfare.

Program Evaluation

Each workshop has been evaluated, at its close, as to achievement of its objectives, by participants and staff. Six months after the first workshop, followup questionnaires were sent to the participants, and the response was positive. Followup from the second and third workshops was less formal and structured, but personal contact with most participants contributed information regarding applicability of content in reality situations. This type of evaluation has assisted the staff in reaching decisions regarding content and direction of subsequent workshops.

The first workshop focused almost entirely on personality development and deviations from the normal. Emphasis was placed upon prevention and rehabilitation as well as care. The second workshop followed somewhat the same format, but as the participants described their needs, interests and desires for the workshop, application of the content became more problem-centered around children and adolescents. As a result of the second workshop, participant comments following the workshop and expressions of need from various groups in the area, the third workshop focused on the person in crisis.

Because of contacts with personnel in a variety of health and service agencies in the area, the faculty has become aware of the need for a continuing education program on the topics of terminal illness, dying and death. The program intends, therefore, to place recruitment emphasis on personnel from long-term patient facilities and personnel and consumers from facilities for the aging.

The strengths of the program have been and continue to be: the quality of the faculty and their untiring efforts in carrying on the project; the calibre of student i.e., interested, highly motivated, variety of experience and openness in discussion groups; and evaluation from participants and staff that forms the basis for future direction. The weakness of the program has been and continues to be: lack of opportunity for followup; time pressure (unavoidable); and lack of objective evaluative tools.

Psychiatric–Mental Health Nursing

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MH11710 1969–1974

Background and Objectives

The philosophy of Continuing Education Services provides a basis for all programs. The concepts of this philosophy are that adult learning is enhanced in an informal, nonthreatening environment; that each is responsible for his own learning; that each is a resource person and is responsible for assisting others to learn; that learning is more effective if the person is actively involved; and that time must be provided for unlearning and relearning as well as learning new concepts with new techniques of therapy/interventions. This philosophy provides the initial guidance for conference planning.

The purpose of this program is to increase mental health manpower through a multidisciplinary approach in programs which focus on current/new mental health concepts in preventive as well as remedial care for all consumer age groups.

The central objectives of the programs are: (1) to design and implement programs for psychiatric mental health nurses and their related health team professionals which focus on current social problems affecting mental health, the prevention of mental disturbances, and remedial care of persons with mental illness; (2) to provide educational opportunities for gaining knowledge and understanding of current/new mental health concepts and related styles of therapy; (3) to develop, through role models, experimental learning of communication skills for a more effective interdisciplinary approach; (4) to encourage through followup techniques, participants' application of the concepts and sharing with staff members in their "back home" situations; and (5) to develop additional evaluation tools which will guide the participants in future learning and guide the staff in future planning.

Planning and Implementation of Programs

Program/grant goals and consumer/client goals provide the specific guidelines for each conference. The broadened multidisciplinary approach presents new variables—education and experience backgrounds are more widely varied, fields of expertise differ even though related, and participants have differing positions of authority, leadership and responsibility. Even so, two common denominators continue to exist. All are "people helpers" and all utilize "relating" as a basic technique.

A new basic structure has been designed for programs, and its flexibility allows the project to capitalize on the variables. The following design is being utilized for 1972–73 programs: In planning the program, experts in the field, representatives of the conference target population, and consumers of health care are involved in brainstorming ideas, problem areas and issues, and select planning committee members. The planning committee members identify theory content, learning experiences, and resource persons, and review applications and select participants. To announce the program, the course coordinator and secretary design and mail flyers and send questionnaires to accepted participants for each to identify his own needs. In implementing the program, the planning committee and staff members plan a flexible structure to include participants' learning needs. Evaluation tools are selected, and the program is implemented. To evaluate the program, the staff, participants, and home agencies provide written and oral evaluation after completion of the program and followup 6 months later.

Method and Content

The following seven programs are planned to meet the central objectives:

1. Communications Through Transactional Analysis: Of special interest to members of the "helping professions," this intensive workshop covers the theory techniques of transactional analysis as they apply to personality dynamics and to the practice of individual and group counseling and psychotherapy. Each participant will have the opportunity both to lead and to be a member of a TA-oriented group with critique offered by the workshop leaders. This workshop will

meet the accreditation standards of the International Transactional Analysis Association and completion of this course, including a written examination, will meet the requirements for regular membership in the International Transactional Analysis Association. The length is 1 week and the enrollment is 30–40 nurses with psychiatric nursing backgrounds.

2. Family Therapy/Counseling: The first week will include theory and action techniques to learn of family structures and family communication patterns. The second week will be the study of "people-helper techniques" through assimilated and real family counseling. A 6-month interim period between the second and third week will allow participants to work with families in their home situations, write process recordings, and return for evaluation and continued advanced study. This course has been submitted to the University of Colorado for Continuing Education Credits. The participants are 30–40 nurses.

3. Dynamics of Cultures on Health Care: The first session is designed to facilitate the impact of cultural differences on communication. In the second session, participants will study the sociometry of their organizations and working groups in relationship to the various minorities and cultures within their health care systems. The third session is designed for back-home application, planning and designing. There are three 3-day sessions (total of 9 days), each divided by an interim period. The enrollment is limited to 40 persons; any three-five member team which includes a nurse may enroll. Other members may be social workers, psychiatrists, psychologists, teachers, principals, psychiatric technicians, etc., and will cut across lines of culture, minorities status and agencies.

4. Assisting the Aged to Cope with the Problems of Living: Multidisciplinary Team Approach: The basic areas to be studied are: 1) the physiological and psychological changes of aging; 2) the social problems of the aged population; and 3) the aged person with emotional problems. Emphasis will then be to examine current care offered and how to bring about change to up-date their care and maximize the integrity and self-work of the aged person. There are three 3-day sessions (9 days), each divided by an interim period. There are 40 participants; any three-five member team of which a nurse is a member may enroll. Other members may include nursing aides, practical nurses, administrators, physicians, volunteer workers who are working with the aged in homes, institutions, and/or in the community with the major population of retirement age.

5. Management of Childhood Problems. By the Adults? By the Child? The first week will be theory on the normal growth and development needs as related to current social problems; i. e., poverty, culturally disadvantaged, etc. The second week will be on how workers can enhance the child's growth with more ability to cope with conflict and decision-making. The length is 2 weeks. Enrollment includes 20 participants; nurses and paraprofessionals who work with children in nurseries, daycare centers, neighborhood health centers and psychiatric agencies.

6. The Challenge of Adolescence: General theory sessions will concentrate on normal growth and development, and the social problems facing the adolescent today; i.e., experimentation with and/or habitual use of drugs; crime, delinquency, and other countercultural behaviors. Action techniques and role-playing will be utilized to assist the participants to gain insights not only of the teenagers' behaviors, but of their own behaviors and interactions with adolescent groups. Team approaches for communications, decisionmaking and limit-setting with this age group will also be studied. The length is 2 weeks and there are 20 participants including nurses and other team members working with adolescent groups.

7. Management of Nursing Care for the Patient Who is Dying: General theory sessions of various cultural views of death and dying and the psychological components of separation anxiety, grief and grieving for all ages. Concurrent small group discussions will be utilized to give participants an opportunity to examine their own philosophy of living and dying, and to understand how this relates to other cultural views and the nursing care they provide. The second week will be devoted to becoming comfortable as well as knowledgable about nursing behaviors and interventions which are patient-goal directed. The length is 2 weeks and the participants are 30 nurses who work in crisis areas and/or with terminal illnesses.

Program Evaluation

The open-ended questionnaires and Kropp-Verner scales are being utilized and they are designed for immediate feedback. Participants will be requested to write their professional goals which they hope to meet through program attendance. At the end of the conference and in 6 months, they evaluate the program's worth toward meeting their goals.

The area which continues to be most difficult to evaluate is the client/consumer of health care services. The Denver-Metro Area Consortium has begun working on methods to collect data without jeopardizing theory relationships. When these tools are available, Continuing Education Services will employ them.

During the year 1972–73, a small research project has been undertaken in which the participants are given a "self-worth/self-esteem questionnaire," prior to the program and immediately following. Reported research indicates that persons with low self-esteems will not be as flexible to integrate new theory and techniques into their "helping services" while those of high self-esteem will be more likely to initiate change. At the end of the programs, agencies will also be asked to complete a questionnaire which will provide information about the "back home" environment where the participants work. Again, a closed system environment blocks and/or hinders participants to initiate integration of new knowledge and techniques.

Continuing Education Program in Psychiatric Nursing

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MH11704 1969–1973

Content and Objectives

The program consists of a number of distinct but associated offerings, central to which is a workshop for developing group skills. The primary objective of this core course, which serves as the entry point to the program, is the extension of the nurse's direct care potential both qualitatively and quantitatively. To achieve this end four specific goals are set: (1) to identify selected elements of group dynamics; (2) to practice using these principles in the classroom; (3) to apply these principles in the work setting by organizing and leading a group; and (4) to demonstrate application at the home agency. Having completed the program, the nurse has the option to attend programs which (1) provide specialized content (Family Therapy Workshops, Geriatrics Workshops, etc.) and (2) present general and basic material for remediation or review (basic psychiatric nursing, psychopharmacology).

Within the model workshop, Working with Groups, experiential learning is emphasized using student participation and feedback. The lecture method is confined to the first day of attendance when basic principles of group work are presented, supplemented by graphic diagrams, schematic outlines of concepts and taped recordings. In the following days of the first week's attendance, students take part in group exercises for the purpose of recognizing change in attitudes and cognition. A specially-devised checklist of group elements is used throughout the sessions—first as a pretest, finally as a post-test and during the course of the six return visits on a weekly basis, to record and report the student's own progress in carrying out the assignment of forming a group of her own.

Small group formation during each session enables the student to assume leader, observer and member roles on a rotating basis. Content provides the opportunity for sharing problems encountered in work performance. At the end of the workshop each student is visited by the instructor when she demonstrates the level of proficiency according to the criteria established on the Group Guide. Three followup sessions at intervals of 1½, 3 and 6 weeks provide data on retention of learning, self-directed plans for continuing education, both formal and informal, and influence on other staff members.

Trainees

Trainees are nursing personnel and allied health care workers responsible for direct patient care.

Two applicants from each agency are encouraged to attend together. One of these must be a registered nurse. Her partner may be another R.N., a practical nurse, nurse's aide, psychiatric technician, activity therapist, social work aide or any other colleague with whom she works closely.

In the past 3 years since this program has operated, the majority of the students were those without college background. Three-quarters of the nurses claimed a diploma in basic preparation. Almost unanimously they stated they had never attended a continuing education program before.

The students represented wide ethnic and cultural backgrounds. Half were white. Of the other 50 percent, 40 percent were black, and the remaining 10 percent were of Spanish and Oriental heritage.

All types of mental health facilities in New York City were represented—voluntary and official agencies. The greatest number of students came from the Municipal Hospital System.

Program Evaluation

Evaluative data come from various sources: (1) Demographic information—each student provides information about herself, her education and work experience; (2) Pre-post tests for cognitive learning based on the specific content of each program. Interim progress is delineated in the Group Guide or checklist which is the basis of the pre-post tests; (3) Changes in attitude are evaluated by each student through the use of a series of impressions about the program, the members, the leaders and the university environment. These forms are completed three times during the course of the program and compared at the end of the program; (4) Workshop evaluation—a five-point rating scale highly specified as to every aspect of the program is completed at the end of the program. One item is the student's request for future programs which serve as a source for new program development; (5) Demonstration visits—records are kept and reports written on the student's performance. Categories match those on the pre-post tests and the Group Guide checklist; (6) Followup sessions 1½, 3, and 6 weeks following completion of the program provide data about the student's personal and professional growth. Information collected at this time includes enrollment in academic programs, other continuing education programs attended, promotions and successful efforts for including other staff members in work projects; (7) Writing skills workshops are opened to those students whose group skills have advanced. They are assisted in translating their innovations into written form which is then included in a printed booklet of writing distributed to sending agencies; and (8) Meetings of Advisory Board of representatives of sending agencies and Nursing Education Faculty to discuss effect of attendance on agency personnel, to assist with decision-making, to make suggestions for collaboration in other programs both in university and service agency settings.

While quantification of data remains inconsistent, a large amount of information has accrued which is capable of being analyzed.

Psychosocial Concepts Applicable to Nursing

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MH11491 1969–1974

Objectives

The general objective of this workshop is to improve the psychosocial knowledge and clinical skills of nurses and thereby improve health care.

Specific objectives of this workshop are to: (1) develop facility in using concepts more effectively to explain clinical observations and guide therapeutic action, (2) further understanding and ability to function in mental health programs at primary, secondary, and tertiary levels, and (3) deepen commitment to continued study and use of a theory-guided investigative approach to clinical nursing.

Methods and Content

Classroom teaching methods include lecture, discussion and roleplaying. Supervised clinical experience is offered in group work, crisis intervention and work with individual patients. Major areas of study are: personality development, crisis intervention, communication, psychopathology, systems theory and group concepts.

Planning learning experiences, context and time allocation are undertaken by workshop faculty prior to its beginning. Alterations are made on student and faculty evaluation as the workshop progresses.

A total of 39 hours is devoted to classroom and group discussion learning experience, (approximately 13 hours per week). A total of 36 hours is devoted to clinical experience. Approximately 12 hours per week is spent in group and individual work with clients. Clinical experience is supervised in small groups of six students each. A total of 24 hours is devoted to this type of supervision (approximately 6 hours per week).

Students

The workshop is open to 36 registered nurses. Trainees' educational backgrounds vary from associate degrees to graduate preparation in areas other than psychiatric-mental health nursing. Learning experiences are individualized.

Program Evaluation

Various means of program evaluation are used. Changes in trainee knowledge and skill are evaluated through pre- and post-testing. In addition, trainees offer suggestions for improving the workshop and indicate areas of satisfaction and dissatisfaction. Faculty meet throughout the workshop to evaluate learning experiences and to plan accordingly. It is anticipated that similar plans will be used in the future.

The program has high potential for replication at local and regional levels.

The program has not had an impact on a specific geographic community because trainees are accepted from all States. Communications received indicate that learning experiences offered to nursing students by nonpsychiatric nursing instructors who have taken the program have changed to include psychosocial aspects of patient care. Also, a large number of trainees have enrolled in degree-granting programs following the workshop. The impact of the program is difficult to assess because trainees are so diverse in educational preparation and in positions held.

Changes in the program are being planned which would permit trainees to undertake the program by clustering at learning centers close to their homes.

The major strength of the program lies in supervised clinical practice which permits application of theoretical content in situations similar to the daily work situation of trainees. Learning experiences can be tailored to trainees' needs.

Weaknesses of the project involve the inability to take into the workshop large numbers of nurses from a particular organization at any one time so the impact of learnings could be increased and specifically measured. Also, the length of the workshop (3 weeks) prohibits service agencies freeing many nurses for this extended period.

The program offers an innovative approach to continuing education in community mental health in that students have direct and shared experiences in primary, secondary and tertiary prevention. Also, the impact of various systems on maintaining health or illness is stressed. Understanding the mechanisms of this impact in clinical situations with groups and individuals provides learnings which may be transferred to trainees' work situations.

Advanced Workshop Psychiatric Nursing Skills

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MH11349 1968–1973

Objectives

The project goal was to enlarge and deepen the competencies of a selected group of professional nurses in evaluating and exploring modes of intervention in family situations in which there is an overt health problem.

The general objectives of the project are (1) to prepare nurses for direct work with families and (2) to work out a feasible format and approach to teaching content and family therapy in 1-month continuing education workshops.

The specific objectives for the participants of the workshop are (1) to acquire competency in assessing the psychosocial and cultural aspects of family interaction and (2) to apply an understanding of systems theories to intervention in "disturbed" family situations.

Methods and Content

The workshop runs for 4 weeks during the Summer Session, carries four credits, and may be taken for graduate or undergraduate credit. The workshop schedule includes a daily lecture presentation by one faculty member for 1½ to 2 hours, and a seminar (analysis of nurse-family data and supervision) for 4 hours per week per trainee; four trainees per one faculty member. The seminar method allows each trainee an opportunity to learn from the supervision and discussion of the work of the other three trainees, as well as her own.

Each nurse participant is principal therapist for a family which is seen in their home twice a week for 1½ hours. In addition, each nurse accompanies one other nurse to act as observer for the 2 weekly sessions of the second nurse. Each nurse also observes weekly sessions of 1½ hours each when a faculty member demonstrates family therapy in a live session via the one-way vision room provided by one of the participating agencies.

No text is required, but the student is expected to do independent study and reading in preparation to meet course requirements.

Evaluations are based on the student's clinical work with a family, the operational definition of a family dynamics concept, analogy of the family as a system, and a clinical paper.

The content of the program includes: (1) Orientation to Family Therapy, a. Guide for Conducting First Interview, and b. Specific Intake Areas; (2) Systems Theory, a. The Family as a Social System, b. Analysis of Social System Functions, and c. Analogies of the Family as a Social System; (3) Concept of Role, a. Role Relationships, b. Socialization—Double-bind, c. Culture as a Programmer—Sociocultural Comparisons, and d. Operational Definitions; (4) Dysfunctional Families, a. Problem Areas in Dysfunctional Families, b. Assessment of Families, and c. Role Revisions; (5) Intrapsychic, Interpersonal, and Systems Approach to Psychiatry, a. Compare and Contrast Theoretical Frameworks, and b. Implications of Theoretical Framework for Therapy; and (6) Termination of Family Therapy.

The Workshop Director had the responsibility for identification and organization of content and directing the participation of the other faculty members. The ratio of one faculty member to four trainees was felt to be a maximum ratio because of the high degree of teaching and supervision required in the short-term program.

The Workshop Coordinator has been responsible for the administration of the workshop; recruitment and selection of trainees; coordination with other university departments; and for soliciting and coordinating community resources, clinical and other.

Students

The twelve trainees per year were nurses who had completed a Basic Workshop in Psychiatric Nursing Skills with a grade of A or B, or who held a master's degree in Psychiatric Nursing, or demonstrated evidence of supervised experience with one-to-one and group therapy.

The population of potential trainees is large, just within the discipline of nursing. As mental health services move into the community and extend the focus beyond the identified patient, mental health professionals need the additional knowledge and skills to help them deal with these complex social systems. That nurses recognize a need for further education in this area is demonstrated by the fact that the program received 67 requests for information and applications for the 1972 Workshop and had 23 qualified applicants from which to choose the 12 trainees.

Program Evaluation

At the end of each workshop, the trainees are asked for a written evaluation of the workshop as they experienced it. In addition, the faculty evaluate the format of the workshop. There was a consensus among the faculty following the summer workshop that the problems in mechanics and schedules had been worked out to the satisfaction of agencies, faculty and students. It is possible to present sufficient, relevant, theoretical content to the trainees about the process of family therapy using the present design. For the most part, the lecture presentations do anticipate the dynamics of families and provide direction for the trainees before the issue arises in clinical practice. Close supervision via daily seminars further ensures a prepared clinician rather than "practice by crisis." The Workshop Coordinator and Director have developed a postquestionnaire to collect systematic data on the functioning of these nurses as therapists. Graduates of the workshops will be asked to describe, by questionnaire, how their practice has been affected by the workshop.

One of the weaknesses of this project is the fact that faculty trainee positions were not included in the plan. The program recommends that in subsequent projects of this kind, select graduates of the workshop return the following year as faculty trainees.

The potential for replication of this program in other areas of the country, and including other disciplines, is excellent. Work is in progress on a final report of this project, giving detailed descriptions of the roles of project personnel, methodology, content, and administration, to facilitate replication. In addition, a contract has been signed with the C. V. Mosby Publishing Company, St. Louis, Missouri, to publish a book using the best clinical papers from the 5 years of the workshop.

Psychiatric/Mental Health Training for ADN Faculty

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MH12415 1970–1973

Background and Objectives

This project was conceived and developed through the cooperation of the Nursing Education Project of the Southern Regional Education Board and the Continuing Education Program at UNC School of Nursing in response to the dilemma of faculty shortages which accompanied the rapid proliferation of new Associate Degree Nursing programs in the Southern region.

This project was designed to strengthen the teaching of psychiatric/mental health nursing in 21 Associate Degree Nursing (ADN) programs in the South. The specific objectives were (1) to train individual faculty members who had no recent or advanced work in psychiatric nursing by increasing their competency in this area of nursing knowledge and skills, and (2) to strengthen the teaching effectiveness of the entire faculty of all participating ADN schools in preparing students to participate in all aspects of psychiatric nursing.

Methods and Content

The project involved three major training methods: (1) instructional sessions for trainees from participating schools at Chapel Hill; (2) interim assignments for trainees in their home community; and (3) consultative visits to the entire faculty of participating ADN programs at their home sites.

The interim experiences were designed to maximize the individual's development through knowledge of resources in the home community, identification and selection of learning experiences in the community, and opportunity to implement new knowledge and to practice emerging skills.

A single faculty member from each participating ADN program will be involved in six interrelated short sessions of 5 days each at UNC at Chapel Hill. These sessions will be offered approximately every 4 months over a period of 2 years and will involve the same individuals throughout.

Project staff selected an adult education model based on their belief about how people learn best. This meant that the participants actively shared in planning their own curriculum and learning experiences, each person was to influence actively the decisions of the group, and curricular decisions were made by a group of 23 persons.

Additionally, implementation of this model meant that project staff saw themselves primarily as facilitators for the group. The goal was to assist the learners as a group in defining their own needs, goals, learning experiences, and evaluative processes, all of which were designed to help to narrow their knowledge and skill gap as practitioners and teachers of psychiatric nursing. The facilitator role extended beyond planning aspects of the sessions in that it also became the staff's responsibility to run-out the selected inputs of the group in a definitive manner for subsequent instructional sessions. The parameters which staff provided for instructional sessions were: (1) the specific learning field as defined and (2) a focus on practitioner role and teacher role.

Consultation

The project staff was committed to provide two consultation services to each of the participating schools. The total faculty of each school was committed to work on some aspect of teaching psychiatric nursing and to seek consultation services from the staff when needed. Most of the requests have expressed broad needs for assistance in integrating mental health concepts throughout the curriculum. The majority of the staff's consultation visits have been of 2 days' duration.

To date, the project staff has consulted with (1) the total faculty group at each of 14 ADN programs in the Southern region; (2) the faculty member(s) having major responsibility for teaching psychiatric nursing at seven ADN schools; (3) 20 chairmen and/or individual participants (via telephone).

Profile of Participants

Participants represent 12 Southern States.

Total Number Participants (Female)			21
Age Range	24–56	Average Age	37
Married	17	Single	4

Basic Education Preparation

Diploma	8
ADN	0
Baccalaureate	13

Master's Education Preparation

Nursing Education	1
Medical Surgical	2
Degree Outside Nursing	1

Program Evaluation

Major evaluative measures in the ADN project included a four-part questionnaire (personal data inventory, school data inventory, interpersonal concepts, psychiatric nursing concepts) and a 20-minute taped individual interview session encompassing the participant's beliefs relating to: (1) learning fields; (2) teacher-student relationships; (3) framework and/or determinants for (a) teaching psychiatric nursing, (b) assessment of behavior, (c) nursing intervention.

During November, 1971, the above evaluative measures were completed by each participant in the project and by an ADN faculty member in 11 nonparticipating control schools located in the Southern region. Both the participating and the control schools will again complete the above evaluative measures just prior to the completion of the project. Additionally, the evaluative measures which are an integral part of each of the instructional sessions are both oral and/or written, group and/or individual and daily and/or weekly. The staff is presently developing an open-ended questionnaire for the total faculty and chairmen of participating and control schools to be completed after the end of the project.

The high level of continuing participation in the project and the very low dropout and absence rate offer some indication of the success of the project.

The clearest indication of the impact of the project is the fact that one participant has already entered a graduate program in psychiatric nursing (September, 1972) and another participant is thinking about entering graduate school.

Project staff has been strongly committed to sharing communications with schools and individuals. They believe the continuous flow of information about the ADN project has not only sustained interest in the project itself, but has also helped to sustain interest in the improvement of teaching psychiatric nursing in the South.

Project Progress Reports have been published in the Agenda Book of the Nursing Council of SREB, which provides an excellent channel for communication to multilevels of nursing educators in the Southern region. A second major communication vehicle for the project has been a brief quarterly newsletter from the project staff giving information about project activities, plans, and other relevant data on the project. These are sent to all ADN, baccalaureate, and graduate nursing projects, and mental health consultants in the South. Five newsletters were sent out between June 9, 1971 and December, 1972.

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Use of the Project as a Model for Further Continuing Education of ADN Faculty

The discovery of total faculty enthusiasm for work on behavioral concepts and the recognition of the effectiveness of consultation assistance to total faculty in this project have led to a new design for continuing education for ADN faculty, which focuses more on the total faculty, in their home institutions, while continuing to work with individuals teaching psychiatric nursing. This new design makes it possible for a training program to effectively reach many more people.

Implementation of the project has also brought recognition that chairmen have particular needs to improve their decision-making skills in working with total faculty on curriculum and related activities. The training methods employed in the present project have proven very successful and will therefore serve as a model for future training to upgrade the teaching of psychiatric nursing in ADN programs, with these emphases and/or differences: (1) the proposed training project will approach the area of psychiatric nursing through the use of behavioral concepts; (2) the training sessions will focus on the total faculty instead of one individual, to ensure that the use of a behavioristic framework will extend throughout the curriculum, and to avoid isolation of the individual teaching psychiatric nursing from other faculty and chairmen. In this way, the project will build on general faculty acceptance of need for work in the area of behavioral concepts and provide individual training and total faculty training which are complementary and mutually supportive.

Continuing Education–Nursing

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MH11157 1969–1973

Objectives

The objectives for the Mental Health Nursing course are:

1. To know and understand the psychodynamics of human behavior, such as: basic concepts of human behavior; basic principles of mental health nursing; contemporary theories of psychiatry; modern treatment approaches to mental illness; mental health needs of contemporary society; and meaning and value of self-awareness.

2. To use oneself therapeutically in establishing relationships with patients: to observe behavior objectively; to analyze observations of behavior in terms of learning needs (make inferences and validate them); to plan approaches to meeting learning and other needs; to identify scientific rationale for selection of approaches to meeting learning and other needs of patients; to evaluate effectiveness of approaches; to reassess needs and proceed again; and to effectively lead a group of patients or nonpatients.

3. To increase skills in human relations and in an effective counseling role: to accept the client as a person of (potential) worth and dignity regardless of race, color, creed, economic status, or behavior; to observe verbal and nonverbal behavior; to listen with undivided attention focused on client and his feelings and needs; to "hear" the important cues in client's verbal and nonverbal behavior; to reflect client's feelings in order to open channels of communication and convey empathy; to clarify client's thinking; to expect client to develop his potential with help; to allow client his right of self-determination except when he is harming himself or others; to relate to client on level of one human being to another; and to help client develop his ability to solve his problems constructively.

4. To participate as an active member of the team in community mental health: to know principles of preventive psychiatry, including crisis theory and community mental health; to intervene effectively in crisis situations; to know resources available for helping persons relieve their distress and maintain health; to determine priorities in mental health care; to know roles and functions of members of a mental health team; to communicate effectively with members of a mental health team and all pertinent resource persons in the community; to assist in mental health education of the pub-

lic; to assist in primary, secondary, and tertiary prevention of mental illness; and to assist in total rehabilitation of mentally ill and mentally retarded individuals.

Methods and Content

Preliminary planning for the course was developed with participation by the mental health-public health nursing consultant, and the Director of Mental Health Services for the State. Continuous planning and implementation take place with assistance from the Continuing Education Committee and faculty of the College of Nursing of the University of North Dakota.

The content areas in Mental Health Nursing (Series III) include: Principles of Patient Counseling; Understanding Group Process; Growth and Development of the Normal and Abnormal Child; The Nurse's Role in Crisis Intervention; The Nurse's Role in Community Mental Health; The Nurse's Role in Therapeutic Recreation and Other Activity Therapy; Meeting the Mental Health Needs of the Geriatric Patient; and Counseling the Alcoholic and the Drug Abuser.

Each week has an average of 30 hours of class including theory and clinical experience. Methods include informal discussions, seminars, role playing, patient interviews, group awareness experiences, individual conferences, written tests. Students may receive credit if they take all 8 weeks and satisfactorily meet the requirements.

Students

The trainees are registered nurses in North Dakota and the bordering States of South Dakota and Minnesota. Sixteen nurses were from hospital-diploma schools; one was from a 2-year Associate Degree program and two from baccalaureate programs. The latter two attended only 1 week during which a course of special interest to them was presented.

Program Evaluation

A psychologist has assisted with testing the students at the beginning and end of the 8-week session. The same tests were given at the beginning and the end of the first two series. Only the National League for Nursing Achievement test in Psychiatric Nursing showed any significant difference. New tests were devised for the students in Series III. A questionnaire sent 6 months after the course asked for any changes they had made in their reading habits, work innovativeness, community involvement, and professional activities as a result of the course. The responses indicated considerable growth in the trainees.

With careful thought and planning, the program has potential for replication at the regional level. Enrollment on the local level has decreased for undetermined reasons at present. Lack of stipends after Series II may account, in part, for the decrease. North Dakota is a rural community with long distances between relatively small cities. Most nurses are married, with families, and have difficulty being away from their families as well as their jobs for any length of time, even a few days. Salaries in North Dakota are lower than in Minnesota.

The program focuses on the priorities in mental health care today. One of its strengths is that it includes clinical experience in a variety of settings. It stresses mental health principles in all aspects of life and has application to daily living as well as professional nursing.

Preventive Psychiatry for Community Care Givers

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MH11643 1969–1974

Objectives

The overall objective of this training program is to teach the principles and practice of Preventive Psychiatry to Community Care Givers. The program is aimed at reducing psychiatric disorders by increasing the knowledge and abilities of nurses, social workers, teachers and other care-giving professionals who work with schoolage children.

The specific objectives are to train participants to: recognize the importance of approaches in preventive psychiatry, identify situations where crisis intervention is appropriate, begin applying crisis intervention principles to such situations, understand the indications for and uses of individual and group relationships, begin individual or group problem-solving approaches, when indicated, and recognize the need for ongoing supervision or consultation in their work and identify appropriate resources to accomplish this goal.

Methods and Content

The workshop makes use of group discussions, readings, written assignments, lectures and films. Strong emphasis is placed on clinical experience complemented by extensive use of role playing and interim assignment.

Utilizing the concept of prevention as a frame of reference for the workshop, the following content areas have been developed: current concepts in crisis theory and intervention, individual counseling approaches and use of the therapeutic relationship, group work utilizing task-oriented and problem-solving approaches, and beginning skills in using and giving consultation.

The first 1-week content area was taught during the summer, followed by seven 2–3 day sessions from late summer through February 1973. Approximately 40 hours are spent in each of the four content areas. Each 40-hour period includes classroom and interim assignment activities.

Students

Trainees selected by discipline include: one nurse, six counselors, one psychometrist, six teachers (secondary and elementary), three volunteers (neighborhood centers and Vista), one school superintendent, four social workers, and two policemen.

Over two-thirds of the trainees reside and work in a two-county area in Northeastern Oklahoma, an area lacking comprehensive mental health facilities and services. First priority in participant selection was given to care-givers from this area, based on the assumption that intensive training in an informal small group setting would develop a feeling of camaraderie beyond the classroom walls. Backgrounds and occupations of participants are varied but all share a common concern: they provide care-giving to young people (preschool through college freshman). The chronological age of participants varies from early 20's through late 50's.

Program Evaluation

Brief narrative subjective evaluations have been completed by participants at the end of the first four sessions. This information has been utilized to plan for each succeeding session, guiding the faculty to move at a pace suitable to the needs of the participants.

At the conclusion of the workshop, 6 months later and 1 year later, information will be requested from participants to allow the program to determine the extent to which the objectives of the project were met and to plan for changes as appropriate.

Several students in the current course have established a two-county committee of representatives of public and private agencies or organizations who offer care-giving services. The purpose of the committee is to identify services available in Osage and Washington Counties in order to eliminate duplication and to strengthen weak areas.

It is anticipated that changes will be made in the project prior to the second offering of this course. These may include the sequence of the content areas—i.e., group work utilizing task-oriented and problem-solving approaches may precede other content areas.

The major strengths of the project include: the variety of the trainees in relation to work role, age, background, etc.; the extensive use of groups and group discussion as a teaching-learning method; the focus which has been placed on families as well as on individuals and groups; and the expertise and flexibility of the faculty in moving at a pace suitable to the needs of the participants.

The major weakness of the project stems from scheduling sessions on weekends. Trainees arrive on Friday evening tired and frequently in need of some time to "wind-down" prior to being able to invest fully in the program. Attention also needs to be given to the trainee selection process to ensure their understanding of the objectives of the program and, inasmuch as possible, to select trainees who are committed to participation.

Continuing Education Program in Mental Health for Oregon Nurses

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MH12974 1972–1974

Objectives

The general objectives of this program are to: (1) add appreciably to Oregon's manpower in mental health by improving the competence of a substantial number of practicing nurses in delivering mental health care to their patients; and (2) assist in coordinating mental health services in selected communities by increasing the nurses' awareness of available mental health services and developing their skills in encouraging appropriate use of these services by their own institutions and by the patients.

The specific objectives deal with the nurse's interactions with individual patients, families, and agencies in the community. The first objective, in relation to the nurse's interaction with the individual patient, is to assist the students to: (1) acquire a unified body of knowledge and understanding relevant to the psychosocial personality of individuals, (2) acquire a beginning knowledge and understanding of communication as a fundamental to all human relationships, (3) identify ways in which man adjusts and adapts in the process of socialization, (4) utilize group discussion as a means of gaining and sharing information, and (5) acquire growth in self-understanding and personality integration as a basis for functioning therapeutically with patients, families, and others.

The second objective, in relation to the nurse's interaction with families, is to assist the students to: (1) understand the forces that influence the development and functioning of individual families; the relation of the family to the physical and emotional health of its members; and how families may utilize community resources to meet its needs, (2) understand the forces that shape the life patterns of individuals and how these are determined by family and society's needs, (3) recognize the contribution of each family member in maintaining homeostasis of the family and that any change or temporary separation creates a void which necessitates reassignment of roles, and (4) understand concepts of crises intervention, normal crises in all families, such as birth, dying, etc., and their obligation in working with families.

The third objective, in relation to interaction with agencies in the community delivering health and mental health care, is to assist the students to: (1) identify the agencies and become aware of the services each provides, (2) become aware of the concept of the community mental health center program and similar coordinated community health care services, and (3) identify the specific mental health problems handled by health-care professionals other than nurses; explore how nursing can contribute to the meeting of these problems, and, in turn, how the techniques used in meeting these problems by other professionals can be applied to the solution of mental health problems faced by nurses.

Methods and Content

The project design is based upon a growth and development, problem-solving, and self-diagnosis concepted model. The trainees are directed through three distinct learning experiences: (1) self-diagnosis of learning needs; (2) knowledge and skill in the development of principles and practices of mental health; and (3) clinical experience under supervision.

The method or format utilized is presentation of the fundamental principles and ideas in the physical, social, and behavioral sciences necessary for formulating a conceptual frame of reference for psychiatric mental health, followed by trainee-determined, small group learning. Liberal use is made of audiovisual, instructional aids, and readings. Credit is awarded from the University of Oregon School of Nursing and may count as continuing education or be applicable toward a bachelors degree.

Most of the requests for content have centered around: care of the mentally ill in a general hospital; better utilization and awareness of local resources; crises intervention; drugs and related problems; medications; communities among staff and local agencies; dying patients; and suicidal patients.

The program plans to hold 30 clock hours of instruction, with continued opportunities for small group discussion, and clinical experience in ongoing service related activities over a 3 to 4 month period.

Students

The primary student population is made up of nurses in the various communities. Most of the nurses graduated from hospital schools of nursing prior to 1950. Most of the areas selected for continuing education can draw populations of 75–100 nurses. In addition, efforts are being made to include: paraprofessionals already involved with professional nursing staff, such as aides and home health care workers; persons nominated by the agencies or advisory committees as being intimately involved with problems, such as members of Parent-Teacher Associations, welfare recipients, and members of ethnic and minority groups; other disciplines already involved in the community, such as ministers, police, child care workers; and persons who can provide situational expertise.

Program Evaluation

Program evaluation is still being developed but includes the following factors: (1) communities are involved in collecting the baseline data; (2) evaluation communities that have already been defined are being utilized; (3) methods to evaluate changes in the social structure are being developed; (4) application to additional problems is being studied; and (5) methods of evaluating involvement, participation and plan of action are being explored.

The program is primarily rural in nature in that programs are taken to and conducted in the rural parts of the State. Continuing Education nursing faculty work closely with the other disciplines which have an interest in mental health, that is physicians, social workers, and psychologists. Some joint programs are being planned to demonstrate how these multiple discipline groups work together.

Since nurses comprise approximately half of the 58,000 employed in health care in Oregon, positive impacts are anticipated. Though actual programs have not yet begun, all communities are actively making plans to develop better methods of treating emotional problems within their own communities.

The strength of the program is in the assistance provided to areas within their own locales and the opportunities to work with and further develop local resources. The geographical nature of the State tends to isolate certain segments and this is rapidly being overcome. Limitations of the project at this time are the number of areas designated as priority areas and the amount of faculty time involved in travel.

Continuing Education Community Mental Health Nursing

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MH12907 1972–1975

Objectives

The project is designed to increase the effectiveness of nurses participating in programs which are a part of, or related to, primary, secondary, and tertiary levels of prevention in mental health by providing learning experiences which will expand and/or formulate new knowledge and skills in the nurses' abilities to provide care to people in a complex social system relative to mental health.

A series of six 1-week workshops will be held at 4-month intervals. The themes of the workshops include: (1) social systems in a community; (2) change through social action; (3) crisis theory and intervention; (4) family theory and therapy; (5) group dynamics and process; and (6) "what now"—plan for action. Specific objectives have been tentatively identified relative to the theme of each workshop. These objectives relate primarily to knowledge and the application of this knowledge in the various learning activities. The project staff, planning committee, trainees and consultants will be involved in the refinement of the objectives as well as the overall design for the workshop.

Format

Workshop format includes general sessions and laboratory learning activities such as interviewing persons in various health agencies, participant observation in health agencies, role-playing, and simulation exercises diads. A consultant, with expertise relative to the theme of each workshop, will be secured to conduct the general sessions. Psychiatric-mental health nurse consultants will be employed to work with trainees in small groups as well as working with the project staff and other consultants in planning and conducting the workshops. These nurse consultants will remain the same throughout the project. Following each workshop, a 1-day consultation visit to each health agency represented by a trainee is planned. Trainees will be expected to complete an interim assignment between workshops, which will be used as a basis for discussion in the next workshop.

Trainees also will be expected to share their learning with their coworkers in their own agency and in other agencies in their community.

Students

Thirty to 36 registered nurses in Mississippi will be recruited to participate in the program. Health agencies will be requested to nominate two nurses, where possible, who would be the most effective nursing practice change agents within that agency. Some of the types of agencies from which participants will be recruited are general hospitals, school systems, public health departments, schools of nursing, headstart programs, nursing homes, and psychiatric hospitals. Some of the participants may not have had psychiatric nursing as part of their undergraduate education. Of those who have had psychiatric nursing, most may not have had their basic psychiatric preparation within the last 5 years.

The project advisory and planning committees will assist the staff in selection of the trainees, using guidelines that have been developed.

Program Evaluation

The primary focus of the evaluation process will be related to change in participants' attitudes and behavior (practice) as evidenced by participants' performances during workshop series, changes reported by participants in their practice and/or the practice of their agencies and/or their coworkers, the reports of the consultation visits, and various written summaries by participants of learning activities.

In order to have a baseline for measuring changes which take place within each participant, and/or agency, certain evaluative tools will be administered "before" the project begins. These same tools will be administered immediately "after" the completion of the workshop series.

In keeping with the project goal of effecting some changes in practice within the agencies represented by participants and/or between agencies, an appraisal of the project's value will be made by the participants and their agencies, in relation to changes attributable in whole or in part to the influence of the project. In addition, an appraisal by the project staff will be made 12–18 months after the series of workshops are completed, to make some judgment relative to the longevity of the changes in the practices of the participants and/or his agency. The data collecting tools will be similar to and/or the same as the instruments used prior to the first and at the end of the last workshop.

Continuing Nurse Education in Community Mental Health

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MH12183 1970–1973

Background and Objectives

This project includes programs for two groups of people, one for practicing nurses with limited experience and formal education in psychiatric-mental health nursing (subsequently referred to as Program I) and the second for nurses with graduate preparation in psychiatric nursing (subsequently referred to as Program II). The latter program was extended in the second and third years to include other mental health disciplines.

The general objectives of the program include: (1) development of an ongoing continuing education program in psychiatric nursing; (2) assistance to registered nurses who lack basic psychiatric nursing knowledge and skill to move into comprehensive community mental health programs; and (3) assistance to registered nurses to keep abreast of change in this area of nursing practice.

The specific objectives of Program I are, in terms of the learner, to: (1) know the current and changing trends in care and treatment of people with mental health problems; (2) understand a conceptional framework related to personality growth and development; (3) understand the coping mechanisms used by individuals to adapt to life situations; and (4) expand knowledge of nursing functions related to caring for people with mental health problems. The specific objectives of Program II are to: (1) develop skills in mental health consultation; (2) explore theoretical premises or formulations of the consultative process; and (3) provide supervised consultation services to nurse practitioners in relation to mental health problems.

Methods and Content

A variety of methods are used to increase participants' acceptance of program objectives and to allow participants active involvement in the sessions. A series of four workshops over a year's period were held in Program I, and a series of three workshops over a year in Program II.

Methods utilized included: (1) case studies; (2) films, video-tapes, and cassettes; (3) work study sessions; (4) group discussions; (5) lectures; (6) between session projects; (7) clinical observations (with discussion of observations made on visits to several community agencies offering mental health care information); (8) student analysis of nursing care problems; (9) reading references prepared and distributed prior to workshop session; (10) independent study; and (11) lending library developed and transported to workshop sites.

Content areas in Program I included: (1) Developments in Psychiatric Care; (2) The Patient as a Person; (3) Nursing Process and Functions in Mental Health-Psychiatric Nursing; (4) Personality Growth and Development; (5) Patterns of Adjustment; and (6) People with Psychiatric Problems. Content areas in Program II included: (1) Preparation for Consultation; (2) The Individual Consultation Relationship; (3) Types of Mental Health Consultation; (4) Assessment of the Consultation Problem; (5) Techniques of Theme Interference Reduction; and (6) Rationale of Theme Interference Reduction.

In Program I, four 2½-day sessions were scheduled over a 1-year period for the same participants, making a total of 80 course hours. In Program II three 3-day workshops, and monthly 2-hour study sessions were held. There was a combined total of 42 course hours, plus one 2-day workshop, totaling 16 hours.

Students

The following disciplines were represented in the training program: nurses—182; mental health workers—four; psychologists—nine; psychiatrists—three; social workers—10; and volunteers—one; for a total of 209 participants. The majority of nurses were prepared in diploma schools and had little or no prior training in psychiatric mental health nursing. The remainder (58) hold masters degrees in Psychiatric Mental Health Nursing.

Program Evaluation

Evaluation is directed toward the participants' performance as a result of the training program. The program objectives are developed by the staff and planning committee with the trainees assisting in their determination through questionnaires prior to the first session, followed by discussion and further refining of objectives at the initial meeting. Differences between current and desired performance are established in order to design the training programs to meet the goals of desired performance. The testing system is then developed and is ongoing throughout the instructional program. On-site visits are made between sequential sessions to assist participants in implementation of new skills and knowledge to work situation.

Trainees represent most community

agencies and institutions, such as hospitals, health departments, nursing homes, and community mental health centers. Through meeting together in workshop sessions, the participants report they have become better acquainted with the services provided to people, and that this has resulted in more referrals for patient services and better continuity and comprehensiveness of care. Some hospitals serve as the inpatient unit for community mental health centers. Nurses in these hospitals report that project programs have enabled them to accept the unit as a hospital service and to work with the people admitted. Personnel organizing the centers were enthusiastic about the helpful support received from the project participants in bringing mental health services to their communities.

There have been two recent changes in the program. The advisory committee is being reorganized to include a broader interdisciplinary representation, and teaching methods have been broadened to make greater use of audiovisual and print media.

Strengths of the program include: (1) Project programs have been taken to outlying areas of the State where there are limited educational opportunities for nurses, and this is the first time that offerings in mental health psychiatric nursing have been available. (2) The nurse trainees are for the main part directly involved in giving care to people. (3) Employers' support of the program has added strength by encouraging people to apply for instruction and arranging release time to keep attendance at a high level. (4) The interest and problems trainees express have been used as a starting point for presentation and content, and the pace of learning has been determined by participant needs.

To further strengthen the program, more staff time could be directed toward providing assistance to participants between sequential sessions.

Continuing Education–Nursing

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Goals and Objectives

To meet future needs, nursing students now in school must be prepared to function in new types of medical and psychiatric settings, such as community mental health centers, regional medical centers, home visiting, day-care units—any place patients and families are. This program is one attempt to assist in the provision of more nurses having better preparation to work in the mental health field. It is based on the premise that nurse educators in the West believe the graduate of the associate degree program in nursing should be able to meet the social and psychological needs of patients, as well as their physical needs.

The long-range goal of this program is to prepare graduates of associate degree nursing programs to use psychiatric mental health content in any clinical area. To reach this goal, those who teach nursing students must be secure in working with mental health concepts. The specific objectives of this program are to: (1) increase the knowledge level of participants in selected psychiatric mental health concepts; (2) develop skills to teach the stated psychiatric mental health concepts; (3) assist participants to communicate knowledge learned at the workshops to their colleagues back home; and (4) assist participants to assess the presence of given psychiatric mental health concepts in their respective programs.

Methods and Content

The design of this program consists of selected faculty members attending a 3-year sequence of workshops, with project activities undertaken at home between sessions, and consultation available to assist with implementation of content throughout the nursing curriculum.

Seven workshops were planned. The first was a week-long (31 contact hours) summer session to introduce the concepts of loss, anxiety, hostility, and stigma. The second was a 2-day (13 contact hours) fall session which focused on the teaching techniques of behavior modification, directive and nondirective interviewing, and problem solving. A 2-day (13 contact hours) workshop held in the following spring explored the use of psycho-drama as a teaching tool. During the second summer of the program, participants spent 2 weeks (50 contact hours) implementing behaviorial objectives they had written for each of the four concepts cited above. Clinical settings included a general hospital and a community mental health center. At the participants' request, 2 days (16.5 contact hours) the following spring focused in more depth on behavior modification techniques, interviewing skills, small group dynamics, and objective writing. The third summer involved another week (41.5 contact hours) in clinical settings, with participants working on improving their skills in using the various techniques. The final workshop is a 2-day (12 contact hours) session on organizational change, with emphasis on simulation and small-group investigation of various approaches to change.

In addition, consultation in home schools, as requested by participants, is provided to assist with the implementation process. Consultants are concerned with helping participants communicate their learning to colleagues. Homework assignments are given to aid in this transfer of learning from workshop to school.

A planning committee, composed of two project participants and two other qualified psychiatric nurses, assists the WICHE staff in selecting content for specific sessions that are especially pertinent to faculty members in associate degree programs. Together they plan, implement, and evaluate the conferences.

An advisory committee of five members includes representation from nursing service, nursing education, medicine, and psychiatry. This committee assists the staff and planning committee by assessing periodic reports for evidence of progress, reacting to the project efforts, and providing some feedback from the community at large.

The WICHE mental health staff, representing several disciplines, provides consultation to the WICHE nursing staff in the development and implementation of this project to ensure an interdisciplinary perspective and to prevent duplication of effort on the regional level.

Students

At the beginning of the project, the advisory and planning committee members selected 70 faculty representing 30 associate degree nursing programs in the West. The age range of the participants is 25–67, with the average age being 40. Their educational preparation varies: one has an associate degree, 23 have baccalaureate degrees, and 46 have masters degrees. Of those with baccalureate preparation, 50 majored in nursing and 19 in another field. Of those with masters level preparation, 7 majored in psychiatric nursing, 15 majored in nursing area other than psychiatric nursing, and 24 majored in areas other than nursing.

Program Evaluation

Personnel, participants, and the schools involved in the program have a part in the evaluation process. Workshop and consultation evaluations have been significant in determining content throughout the program's progress. The final evaluation will include a comparison of the presence or lack of given concepts in courses other than psychiatric nursing, as well as written reports of faculty and consultants involved in the program.

Initial written and verbal communication from participants indicate the use of the content of the workshop in curriculum building in various schools. Spontaneous correspondence from participants demonstrates the impact on the individual instructor, which leads the staff to anticipate a spread effect to other faculty and students. Faculty are discussing the use of areas other than the general hospital when introducing mental health concepts in the beginning nursing courses (i.e., convalescent homes, community mental health centers, day-care centers).

Deans, directors, and faculty from programs not participating in the project are requesting the papers presented at the workshops. (Papers are being provided to these schools by charging for the cost of printing and mailing.) In addition, consultation to aid integration of mental health concepts throughout the nursing curriculum is now being provided to nonparticipant schools.

The strength of this program is primarily in its design. The dual approach of theory and practice, with followup consultation available, seems to have been enthusiastically received. The verbal and written comments of the participants indicate that application of content at home is occurring with praise going to the chances to "try out" new techniques in the workshop atmosphere.

The primary problems are the difficulty in maintaining continuity of attendance, due primarily to faculty members changing positions, and limitation of out-of-State travel funds.

PART 5

CONTINUING EDUCATION FOR SOCIAL WORKERS AND RELATED PERSONNEL

Continuing Education in Community Mental Health

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MH13018 1972–1975

Background and Objectives

In its initial grant application, the School of Social Work of Adelphi University applied for funds to hire staff to plan, develop and provide educational and training programs which would enhance the mental health component of service delivery primarily in minority group communities. Basic to the proposal was a commitment to the concept of community involvement, wherein both the providers and consumers of service would participate in all phases of the project design— identification of training needs, selection of priorities, development of programs as to format and content and evaluation.

The School of Social Work sees this process of community involvement as consisting of several steps: Phase 1—Identification of Needs; Phase 2—Establishment of Priorities; Phase 3—Program Development; Phase 4—Program Implementation; and Phase 5—Evaluation.

The identification of training needs has been built upon a process of involvement with the community in which the School has been engaged for several years. Together with suggestions solicited from staff and faculty operating in a variety of agencies whose services have a mental health component, i.e., hospitals, schools, community action programs, the School of Social Work, as part of its continuing education program, was able to offer a number of short-term courses in the 1972 fall semester. These included eight session workshops in: Work with Alcoholics and Their Families; Techniques of Crisis Intervention; Marital Counseling; Casework with Adolescents; and Work with Groups in Drug Treatment Programs.

Although each of these courses was taught by a professional social worker, they were designed to be of interest and value to all those with a professional interest in the subject. It is interesting to note that among the sixty participants in the programs were seven nurses, three ministers, six caseworkers from social service departments, five guidance counselors and two school psychologists. In addition, many agencies were represented by both professional and paraprofessional staff.

In the spring semester, the School of Social Work is cosponsoring with the School of Nursing a group of courses which will reflect, both in curriculum development and program implementation, input from both disciplines. The courses which are planned are: Techniques of Crisis Intervention; Counseling Adolescents in Aspects of Human Sexuality; Effective Work with Paraprofessionals; Community Organization Concepts and Techniques; and Work with Alcoholics and Their Families.

Of these five courses planned, four will be team-taught by a social worker and a nurse. At their conclusion, the courses will be evaluated as to their impact on interdisciplinary cooperation. It is anticipated that this initial experiment will provide the faculties of both schools with valuable insights which can be utilized in planning additional interdisciplinary courses in mental health.

In addition to the development of the aforementioned educational programs on the Adelphi campus, work has begun on reaching out to the identified target communities to ascertain in greater specificity the types of training which they perceive as needed in order to improve the mental health aspects of service delivery.

The Advisory Committee in Continuing Education in Mental Health, established jointly in 1971 by the Schools of Social Work and Nursing, was reconvened in November, 1972. Since its members include community leaders, professionals in the mental health field, and representatives of the target communities, it functions both as a valuable source of suggestions and as a sounding board for testing out tentative plans.

Several decisions were made at that meeting which will influence the directions in which the project will move in its initial year of operation. First and foremost was an almost unanimous sense that in selecting an initial target community for intervention, the Village of Hempstead will be given the highest priority. Hempstead has the largest black population on Long Island and a rapidly growing Spanish-speaking community which now numbers in excess of 3,000. Furthermore, it is an area characterized by high need and low services. Geographically, it is adjacent to the University.

The project staff has also suggested an additional focus on the community of Long Beach, Long Island, which is experiencing the pangs of the new suburban crisis in the form of a rapidly expanding minority population with concomitant intergroup social problems.

The Advisory Committee suggested that in developing training opportunities, the approach should be one which cuts across the multiple problems and concerns of the community's residents as they attempt to seek solutions. Although it would be possible to develop training programs around a single problem area, i.e., retardation, aftercare, problems of motel living for public welfare clients, etc., each of which are real problems for the community, more mileage could be obtained by developing training programs which would enhance the knowledge and skills of all levels of staff working with a variety of mental health problems.

In developing an approach and a timetable of activities, additional input was sought from community leaders and professional and paraprofessional staff working in the poor, ghetto communities of Nassau County.

The following timetable for program operation is projected for the next 18 months:

Community Programs

In the 3-month period, December 1972—February 1973, the needs of the communities of Hempstead and Long Beach will be further defined. Although it is well known that there are universal problems which confront the poor in any community as they attempt to negotiate with the existing systems of service delivery, each community has its own set of needs and mental health priorities.

A preliminary survey has already been made of the various agencies which provide service in Hempstead, and several community leaders have been identified. They have provided useful leads in establishing the initial educational offerings. It is intended that communication with both the agencies and the consumers will continue to be broadened to determine 1) what problems or gaps in mental health services are encountered by the community, 2) which services are used by which groups in the community, 3) what problems are encountered by the agencies and what resources are required to better serve the mental health needs of the community, and 4) what specific educational offerings may be necessary to remove obstacles and to enrich mental health services.

Based on this assessment, two or three courses will be developed to be conducted outside the walls of the university. Content, level and types of trainees, format and structure will reflect the overall goals to be achieved in the educational program. Community-based courses along with the continuing education courses in mental health at the university provide a variety of approaches to encourage participation. One or more of the following community-based courses will be offered between the months of March and June 1973, in Hempstead and/or Long Beach: Effective Utilization of Resources; Understanding Your School Age Child; Ethnicity in Relation to Practice.

All of these courses will be offered in the target communities, at no charge to the participants. Based on the initial response, finding suitable classroom space in the communities will not be a problem. Several agencies have already offered their facilities. Problems of dates and times have not yet been resolved although it is hoped that classes could be scheduled within the work week to ensure maximum participation. Faculty for the courses will be recruited both from the community and the university. In either case, curriculum development will be a shared responsibility of faculty, community agencies and participants.

In the second year of the project, two other target communities in addition to Hempstead and Long Beach will be selected. Utilizing the model of community involvement developed in the first year, new programs will be designed in response to the identified needs of each community.

A minimum of ten courses will be offered in the 1973–74 academic year. In some cases, new curricula will be developed; in others, a successful program will be repeated for a new group of participants. It is conceivable that in the original communities a series of courses will be designed, each building on the knowledge, insights and skills acquired in an earlier program.

The Joint Advisory Committee will meet periodically to review progress, discuss new approaches, solicit suggestions for courses and faculty, and help in the evaluation process.

Information acquired throughout the project, particularly in relation to the identification of training needs, will be shared with other schools in the university in the hope that new courses relevant to the concerns of the community will be offered.

On-Campus Programs

The development of on-campus continuing education programs in mental health will parallel efforts in the target communities. In planning new course offerings, the knowledge and insights acquired by intensive collaboration with community leaders and practitioners in Hempstead and Long Beach will be utilized. For example, the Advisory Committee has suggested that a program be organized for personnel managers of companies which employ large numbers of blacks and Puerto Ricans. The purpose of such a course would be to sensitize the companies to the special mental health needs of these groups and to develop appropriate resources to meet these needs. This possibility will be further explored in the hope that such an institute could be offered in the late spring or early fall of 1973. Having already established a mechanism for interdisciplinary cooperation with the School of Nursing, it is anticipated that this aspect of the program will be strengthened in the future. It is expected, moreover, that the two schools together will be able to enlist the cooperation of other departments in the university, i.e., education and/or psychology, in the development of courses in which the participants would be drawn from a number of disciplines.

In working together, it is hoped that much of the duplication which has characterized past efforts in program development will be eliminated.

Specifically, plans for the next 18 months call for the offering of a minimum of six short-term courses in each of the following periods: spring 1973, summer 1973, fall 1973 and spring 1974. Each course will be designed to meet specific objectives. In some instances, the goal will be to impart knowledge; in others, to teach specific skills. A third group of programs could conceivably focus on attitudinal change. It is intended that all levels of staff will be involved in these programs—administrators, professionals and paraprofessionals. Whatever the particular purpose, the program as a whole will be geared to the improvement of mental health service in a given community.

Continuing Education Emphasis: Training Trainers

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Objectives

The project has two parts, which is reflected in the title, Continuing Education—Emphasis: Training Trainers. The objectives are to develop a program of educational services for individuals, from volunteers to professionals, in social and mental health services, and for the established and developing agencies and human services institutions throughout New England; to increase the number and competence of individuals responsible for training others; to produce programs which are relevant to the major social problems and which stimulate enthusiasm in the learners for a more knowledgeable and skillful approach to their work. Another objective is the development of courses, workshops, and consultation as vehicles for action or change leading to the improvement in services. This objective produces a theme: education for practice, and a methodology: education for adults, both of which become objectives. A seventh objective of the project is coordination within the university and within the other local schools of social work. Another objective is the development of credit courses in social work at the bachelor's level in the university's evening division. Faculty and community advisory committees participated in setting these objectives which have resulted in a variety of programs which have specific objectives too numerous to mention here.

The "Training of Trainers," renamed

"Educating the Educators," project will be described in some detail. Its objectives are to develop the teaching function of mental health and social agencies and the teaching skills of staff members so that the agency can offer courses to other professions, to the community, and others in subject areas which are the particular competence of the agency. A second objective is to provide a program, "On Becoming a Teacher," for mental health professionals who wish to develop skill in curriculum development and teaching technique in order to become teachers in their own agencies or in the community. A paper is available on "Evaluating Teacher Competence in Continuing Education," published in CSWE *Reporter*, Fall 1972.

Methods and Contents

The development of all educational programs utilized a systems approach and community organization techniques. The development of specific courses combines group work techniques and use of adult learning methods. This method as used with agencies consists of the administration and staff consideration of the problems of service delivery and practice in the agency in order to identify together the learning needs of the institution and to design appropriate programs. This approach, when used in the "Educating the Educators" project, results in a course which includes examination of selected learning theories, the identification of the characteristics of the learners, and their learning needs, the setting of objectives, the organization of the content, the design of the educational experience and the evaluation. The examination of the class group process, practice teaching before the class and observation by the instructor in an actual teaching situation are included. The length of the program varies from 14 to 24 class sessions with subsequent consultation as needed by the individual.

Participants

Some 1200 people representing the range of workers within mental health and social services participate each year. In the "Educating the Educators" project there are eight centers involved and approximately 75 staff members. They have master's degrees in social work, although there are psychiatrists, nurses, psychologists, and mental health workers without professional degrees in each setting.

In the course "On Becoming a Teacher" there have been in each of the past 3 years some 12 to 20 participants who have degrees in the mental health professions, experience as practitioners and beginning experience as teachers.

Program Evaluation

The evaluation of specific courses and workshops is conducted through an evaluative questionnaire and class discussion based upon the original learning objectives. Just beginning is a major piece of evaluative research on the effectiveness of the "Educating the Educators" program.

Replication of the "Educating the Educators" program should be possible in other communities. A paper on it will be published shortly. The other activities of the Division, such as the work with State mental health and public welfare systems, area mental health board training, and the short-term courses and institutes are not dissimilar from programs which exist elsewhere throughout the country. The program of "The New England Center for Health Consumer Leadership," which is unique, could be replicated.

Probably the unique aspect of the Division is its emphasis on developing education as a significant aspect of the organization. The Division is convinced that putting emphasis on enabling organizations and systems to do their own continuing education programs is most valuable.

The major strengths of this project are the quality of the participants' involvement in it and its programmatic cohesion around the basic objectives of education for change and action. Another major strength is the consistency of the process which is utilized in developing all programs. A weakness is that as a project becomes larger, increasing proportions of time are spent in maintaining the program rather than in developing new aspects. There is no dearth of creative ideas among the staff but there is a dearth of man and woman power. The innovative part of the program is the process of program building based upon the learners' and institutional needs, preparing individuals and agencies to join the Division in carrying out continuing education throughout New England.

Continuing Education—Social Work

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MH11158 1968–1973

Objectives

The Project on Continuing Education of the Council on Social Work Education was established in 1968 to achieve two overall goals: (1) to help schools of social work create new continuing education programs (CEPs) or increase the effectiveness of established programs, to strengthen their capacity to provide a range of educational services tailored to new needs and new priorities in practice delivery; and (2) to encourage schools to give strong emphasis to mental health, to reach out to the broad community mental health system and other agencies dealing with critical mental health problems. These objectives were established with guidance from schools and practice constituents. They have been periodically reaffirmed by a Committee on Continuing Education, which is actively involved in all aspects of its work, and which shares in determining goals, program and priorities. It includes faculty from graduate and undergraduate programs, mental health services personnel, and students, who are also representative of various ethnic minority groups. The Project reflects the total CSWE concern for linkages among its various levels, for assuring cultural diversity in learners and faculty, for changes in service delivery systems which are dysfunctional, for training for differential use of manpower. CSWE sees the Project's role as providing leadership, services, and coordination to CEPs.

Four specific objectives derive from the above. First is "to increase the insights and skills of those giving administrative and program leadership to continuing education in social work." Two workshops for directors and coordinators were conducted, at Syracuse University in 1970 (4 days) and at the University of Kansas in 1972 (3 days). Seventy-two participants from 59 schools deliberated with experts and colleagues on issues and problems of their primary concern. Planned with full involvement of the participants, the workshops responded to the participants' own goals and options regarding content. Flexible scheduling allowed them to use faculty for individual and group consultations. The first workshop dealt with program planning for adult learners, mental health priorities for continuing education, components of a comprehensive continuing education program, and administrative structuring and financing of continuing education. Goal-setting was the keynote. In the second workshop, background papers on "organization and program aspects of continuing education" and "learning concepts and teaching practices in continuing education" added focus and depth to the deliberations. Interdisciplinary approaches and accountability were explored. Participants included experienced and new directors of CEPs (program directors of NIMH-funded projects were specifically invited), deans, associate deans, and faculty. Evaluation processes involved participants and faculty during and following the workshops. Formal and informal followup gave evidence that desired outcomes were substantially achieved.

CSWE's Annual Program Meeting offers further opportunity for interchange and learning. "Concepts basic to continuing education" and "continuing education: an integral part of the social work education continuum" are recent themes. General sessions are scheduled, followed by concurrent workshops. In addition, individual schools are urged to plan short-term programs for continuing education directors and faculty as part of their own CEPs. Groups of schools in geographic proximity are encouraged to undertake joint educational ventures. As illustration, three schools, together with CSWE, are currently planning training of faculty for continuing education.

A second objective is "to advance the quantity and quality of continuing education in the schools." The Project provides consultation in relation to developing new programs, advancing a school's planning, building linkages with the community and within the university, staffing the programs, helping a new director get started, seeking necessary funds, promoting a strong mental health component. The new continuing education thrust on the undergraduate level is expected to increase requests for assistance.

Guidelines are being prepared. A task force has been charged (1) to identify principles, goals, and processes for planning and implementing a CEP on graduate and undergraduate levels, and (2) to establish criteria against which schools may measure the scope and quality of their programs. The draft is now ready for critical review by the Committee and by a selected interdisciplinary group of readers.

The third objective is "to keep schools informed about news, events, and resources relevant to continuing education and mental health." Information is disseminated through the newsletter EXCHANGE, which reports on teaching materials, program initiatives, published documents and resources, conferences and meetings, and similar items. An annual listing of summer programs in social work facilitates planning by delivery systems for participation in continuing education by their staffs.

A survey on the status of CEPs in social work at colleges and universities is underway. Data are being compiled and analyzed. Preliminary findings show that considerable progress has taken place during the past 4 years, measured by an increase in the number of CEPs in schools, the number of full-time people engaged, size and scope of programs, amount of faculty time assigned more sharply defined objectives, more interest in evaluation, more comprehensive planning, increased enrollments, variety of target groups addressed, increase of mental health content, extent of university commitment and support, strengthened linkages with agencies and organizations and with other units of the university, and more interdisciplinary efforts. Continuing education is increasingly considered part of the social work education continuum.

A fourth objective is "to increase the published resources in continuing education in social work." The *Guide* and *Survey Report* are scheduled for publication in 1973. A *Monograph* on continuing education is planned as a companion document to the *Guide*. It is intended to present a coherent system of concepts and principles, constitute a basic resource for planning, and provide the base for stimulating systematic thinking and further development of knowledge about continuing education. Interdisciplinary participation is envisaged. The monograph is dependent on new funding, and resources are being explored. In addition, nine articles on continuing education appeared recently or will be published in CSWE's two periodicals.

The Project is now ready to focus directly on training for the use of social work skills in interdisciplinary community mental health systems. A new plan will involve CSWE, schools of social work, and the interdisciplinary community mental health system, nationally and locally, in a collaborative process which will bring the expertise of both groups to the service of community mental health delivery systems. Key objectives are: (1) to devise and test various educational models by which CEPs may organize and structure learning experiences for social workers engaged in community mental health services; (2) to identify the learning-teaching issues specific to continuing education for mental health purposes, and train the faculty who will test the models in instructional methodology; and (3) to produce a document which will report the significant experiences, principles, and learning achieved and serve as a resource for continuing education in social work related to community mental health.

A chief strength of the Project is its national perspective, which permits it to reflect trends, stimulate collaboration, promote interchange and learning, encourage flexibility and innovation, and move toward ever higher standards.

Continuing Education–Social Work

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MH11430 1969–1973

Background

From June, 1969 through July 30, 1972, the School of Social Work at California State University, Fresno, was the recipient of a Continuing Education Grant award. Due to a change of personnel and the need to reassess the direction of the project the school was allowed to extend the project date from 1 year (with no additional funds) to employ one person to contact various community groups, particularly the ethnic minorities, to (1) determine the current continuing education needs, particularly of ethnic minorities; (2) to involve potential consumers in a determination of continuing education needs, particularly ethnic minorities, and (3) to determine current resources of personnel and funds available in the community to meet these needs.

The project's proposed program would provide an opportunity for continuing education in social work, with a specific focus on improved mental health to an estimated 1,500 persons per year, at an equivalent of one academic credit per person per year. It is estimated that enrollment would rise to approximately 2,600 persons, at one credit per year per person, at the beginning of the third year. This program is to be administered by the School of Social Work, with the collaboration of other schools at Fresno State University, other public schools and colleges within the community, with the involvement of mental health and other agencies in the community, and an advisory or policymaking committee reflective of diverse elements in the community including the black, brown, and American Indian ethnic minorities, whose function will be to deal with continuing education priorities.

Program Characteristics

There are two basic program characteristics. The first program will be interdisciplinary, and its conceptual base is grounded in social systems theory and processes, which recognize four primary target systems of planned change for improved mental health, that is individuals, primary and peer groups, formal organizations, and the community as a macro-social system. Continuing education will focus on content relevant to all systems, e.g., interviewing, crises intervention, child guidance, problems of aging, alcoholism, deviant behavior of youth, emotional problem of the disabled, staff development of line personnel, and other problems confronting the delivery of mental health services, culture and community, with a specific focus on the culture, or subculture of such ethnic minorities as blacks, Chicanos, and American Indians. The second program characteristic is that the continuing education program will be flexible, and comprise not only classroom teaching, but workshops, institutes, courses at agencies, etc.

Participants

Since the basic mission of the School of Social Work is to provide training for professional practice of social work on a BA or Masters level, the most strategic use of this capability is to focus the continuing education program primarily on the training of staff, within formal organizations, for improved delivery of services related to mental health. Based upon extended discussion and site visits to agencies in the community, it is estimated that the first year will provide continuing education to approximately 700 paraprofessionals in agencies who do not hold a college degree; 200 professional employees holding a Bachelors degree, 300 employees who have a graduate degree and approximately 300 housewives, members of families not in formal organizations.

Program Evaluation

The method of program evaluation would have several component elements as follows:

1. The first component element is the development of a consistent, systematic, and periodic reportorial system—a report form which will yield data as to the results of continuing education in mental health. Such a report form must be developed at the beginning of the program, and this is particularly necessary because the program will be handled by a range of agencies such as the Community Hospital (Fresno), the Short Doyle Clinic, Public Welfare Agencies, etc.

2. The second component element is the development standards of effectiveness. While the measure of effectiveness of mental health-social welfare operations remains rather difficult to quantify, nevertheless it is felt that some attempt should be made to demonstrate the effect of continuing education in mental health on several levels as follows:

a. On the individuals participating and the extent to which they respond attitudinally as well as behaviorally, i.e., altered role performance, whether the roles be organizational roles, familial roles, parental roles, etc.

b. The impact on agencies participating in the program, particularly mental health delivery systems, and the extent to which such a continuing education program has aided them in achieving their respective mission.

c. The impact on the mental health and social welfare community, namely, the functional community, and the extent to which the continuing education program has accelerated linkages between agencies for the solution or alleviation of mental health problems. This element of evaluation is of considerable importance, for the many problems in mental health-social welfare have to do with the establishment and maintenance of cooperative interagency relationships to handle the multifaceted problems facing individuals, families, peer groups, with mental health, social welfare problems.

During the first academic year, it is proposed that an individual would be employed to develop a reporting system which is consistent and develop evaluative criteria of effectiveness. It is not contemplated that the time required will exceed 4 days per month while school is in session. Once the program gets underway and there is experience in the continuing education program, it is proposed that the individual would spend several weeks during the summer recess on intensive evaluation of the continuing education program.

Continuing Education–Social Work

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MH11652 1969–1973

Background and Objectives

For many years, the School of Social Work, University of Hawaii, had recognized the need for educational endeavors by those employed in the social welfare field but was of necessity bound in by the lack of proper staffing. The regular staff, pressured by graduate educational demands as well as the rapid expansion of the School, met demands for continuing education as well as could be expected. In the fall of 1966, a faculty continuing education committee was formed and major social welfare agencies were canvassed as to the identification of educational needs with their staff. Clearly, the results pointed to and directed the committee's efforts to establish such a continuing education center which would offer a comprehensive and expanding educational program. A stepping stone to the fruition of meeting such needs was the submission and approval of a grant to and by the National Institute of Mental Health to meet the continuing educational needs of the mental health manpower in the community. In July 1969, the beginnings of a continuing education program emerged with the appointment of a project director, and, later in the year, a full-time program coordinator.

The continuing education program has as its broad objective the upgrading of the knowledge and skills of differential levels of social welfare practitioners, thereby linking the community and school through educational programming. The term "mental health personnel" was defined broadly to include all personnel in programs directly serving people with social problems; hence, the term "social welfare personnel." (As will be noted later, the consumers of the continuing education program have mainly come from the mental health field).

The specific objectives are to: (1) devise educational programs such as workshops, seminars, institutes, colloquia, courses, etc. to improve the effectiveness of existing social welfare manpower ranging from the professional to the nonprofessional personnel; (2) work with community agencies and professional organizations to make continuing education an integral part of each agency's operation so that the quality of service is constantly being examined, tested, and improved; and (3) develop the continuing education program in a way that it becomes an integral part of the School of Social Work and of the University and that comprehensive mental health education becomes a permanent and important part of the University's and School's educational program.

The continuing education program staff consists of a project director (10 percent), a full-time program coordinator, and a half-time secretary to carry out all the administrative aspects of programming. However, various advisory committees were formed for the purpose of providing guidelines and the necessary leadership in determining the nature and kind of continuing education programs. These are the general advisory committees composed of representatives from major social welfare agencies in each of the four major islands, Oahu, Hawaii, Maui, and Kauai; the College of Health Science and Social Welfare Community Mental Health Continuing Education Committee for interdisciplinary inputs; and various ad hoc committees for planning of specific programs.

Methods and Content

A variety of approaches has been used in accomplishing the objectives of the program. Over the span of years, monthly colloquia of 2 to 4 hours' duration on particular current issues and concerns were presented by eminent scholars visiting Hawaii or by experts with special talents and interests; e.g., "Childhood Fantasies," "Hypnoanalysis," "Planned Organizational Change," "Minority Adaptation to Poverty," etc. One-week summer institutes (8 hours daily) for 2 weeks during the summer of 1970 and 1971 afforded the trainees an opportunity for an interchange of ideas and experiences and for exploration in depth into practice methods, roles, issues, etc. These learning experiences accomplished the following: learning of new approaches, treatment or otherwise; reinforcement or updating of familiar approaches; and exploring expanding professional roles.

Throughout the school year, periodic 2 to 3-day workshops and evening or Saturday credit courses were offered in an attempt to cover the needs of as many practitioners as possible. These ranged again from treatment approaches (such as crisis intervention, family therapy) to community development (social action approaches) and to helping practitioners become better aware of the changes taking place in society which will inevitably affect practice; e.g., "Changing Family Life Styles."

The cosponsorship of a number of workshops with the School of Public Health (such as the One-Parent Families and Family Therapy) provided the means of an initial step towards interdisciplinary continuing education programming. Consultation with various social welfare agencies around staff development in-service training also complemented continuing education activities. This year, the practicum instructors in the field of mental health are being offered a continuing education program on community mental health to begin developing a more integrated baseline approach to comprehensive mental health education.

Students

Through the programs, the School has been able to reach out to all levels of social welfare personnel (social workers, nurses, aides, child care workers, teachers, school and vocational/employment counselors, curriculum specialists, public health personnel, psychiatrists, psychologists, and others—both line staff and administrators). The number of persons from each discipline attending the offerings varies from one program to the other, but it is estimated that 500–600 different individuals have participated in one or more of the offerings.

Program and Evaluation

Though the value and importance of a systematic built-in program evaluation design is recognized, this major undertaking was not done. Whether this would have been practical and feasible considering factors of manpower, economy, etc., is difficult to predict. Evaluation questionnaires, as well as oral feedback, served as the major tools to assess the effects of the educational experience upon the trainees. Followup sessions, or repeat of the same offering, also pointed to indications of successful impact.

Consultation resulted in a number of outcomes: (1) initiation of a staff development program based on newer insights and value shifts in human behavior for the Hawaii Housing Authority; (2) planning and implementation of a continuing education program (staff development and inservice training) for the Human Services Center and Quick Kokua Program of the Kalihi-Palama area, two innovative service delivery programs; (3) cosponsorship of offerings with other organizations, such as the private social welfare consortium, NASW, Hawaii Chapter; and (4) providing inputs for better inservice training programs to various agencies.

There is little doubt as to the continued need for a continuing education program in mental health; mental health again defined in terms of any or all factors affecting the well-being of an individual group or community. This project has strengthened the impetus for the School to continue such a broadly based program. Also, it was increasingly recognized that the social problems in our society are so complex that a multidisciplinary approach to problem-solving appeared not only to be sensible, but in need of experimentation. Paralleling this development, then, was not only the need for updating the skills and knowledge of the helping professions, but a need to examine and implement ways of uniting together in an interdisciplinary way. This program is attempting to do so with the continuing education committee on community mental health and the Division of Mental Health.

Continuing Education–Mental Health

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MH11479 1968–1974

Background and Objectives

The goal for this 3-year project is to develop an interdisciplinary continuing education program that becomes an integral service within Maryland's Mental Hygiene Administration. The present project has developed from an earlier project also funded by the Continuing Education Branch, "The Continuing Education Program for Social Workers in Mental Health."

This project's main objective is to develop a pattern of training interventions that will assist the implementation of key changes being planned for the delivery of mental health services. Specifically, the project begins at a time when the Mental Hygiene Administration's top leadership is initiating a major reorganization of existing resources in order to link hospital and community professionals and facilities in a unitized system of service delivery.

The project has a multidisciplinary Advisory Council, of which the Commissioner of Mental Hygiene is a member. Decisions about the project are made by the Project Director in collaboration with the Advisory Council.

Methods, Content and Participants

The project is now in the midst of planning activities which will support the reorganization program as relevantly as possible. The approach originally proposed is still fundamentally appropriate: that a sequence of 20 person cohorts representing the several disciplines participate in 1-day-a-week seminars intended to help them develop system-assessment and consultative skills. The selection of participants and the exact nature of their training will now be influenced by the emerging opportunity for the project to take a proactive role in a major program of organizational development. It is anticipated that various training approaches will be utilized to supplement the small-group seminar series, according to the point at which the system is in the change process. For example, there is an immediate need to assist key field and headquarters staff in the system to evaluate existing county-unit modes (in and outside of Maryland) for application to their local planning. Another year we expect to respond to such new needs as for training in unit leadership.

Urban Crisis Training Center

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MH11822 1969–1974

Objectives

The goal of the Urban Crisis Center has been to provide a series of vital programs designed to confront the critical factors of intersystems interface and their potential and actual implication for community mental health. The objectives of the various programs have been to improve the understanding and capabilities of human services personnel who relate directly to minorities and disadvantaged people in urban areas. These staff development and career training programs for practitioners in the broad area of human services have focused on enhancing service skills and attitudinal change.

Methods and Content

The training methods employed in the various programs offered by the Center vary somewhat from program to program, but generally employ group discussions, buzz sessions, mini-lectures, lectures, role play with or without the use of video equipment, simulation games and field trips.

The specific training content areas covered in the various programs provided by the Center during 1971–1972 included:

Training Contracts:

1. Police training-community relations personnel. Content: Role function, use of community resources, developing police training tapes, utilizing video equipment, discussion of leadership training. Hours of training: 80 hours, 2 sessions per month, 10 months.

2. Police training-inservice departmental wide training, captains to patrol officers. Content: "Communications in the 70's covering specific topics as: attitudes, police-community; arrest procedures as viewed by police-community. The need for communications between police-community. Eight hours of training per individual.

3. Police training-statewide by regions. Content: Determining community relations training needs, three regional meetings. Five hours of training per participant.

4. Correctional Setting-Social Education Program. Content: Institutional culture, adult learning theory, group discussion techniques, self-awareness, curriculum design, training methods, evaluation procedures. 36 hours of training.

5. Street Club Workers Training Program. Content: Group work, community organization, adolescent behavior, supervision. 128 hours.

6. Drug Abuse Training. Content: Drug abuse from a medical, psychological, social view, types of drugs used, treatment modalities, life styles, resources. 24 hours.

7. Regional Planning Interns. Content: Community organization models. 6 hours.

8. Social Services Department. Content: Providing services through family and non-family groups. 6 hours.

9. Training Unit-State Department of Mental Hygiene. Content: Determining training needs, setting goals, establishing learning atmosphere, designing training programs, training methods, evaluation techniques. 15 hours.

10. Department of Social Services. Content: Supervision-group and one to one. 12 hours.

11. Department of Social Services. Content: Working with groups, family and non-family. 30 hours.

Workshop Offerings:

1. Services to the Clinical Group. Content: Introduction to a frame of reference for clinical group work; problems of group management and their solution. 30 hours.

2. Essential Problems of Supervision. Content: Functions and responsibilities of supervisor for: standards and performance, teaching and development of staff. 30 hours.

3. Child Care. Content: Understanding human behavior, problems of separation, life style of black families, aggression, hostility, group dynamics. 30 hours.

4. Services to the Aging. Content: To sharpen and update knowledge of aging and practice, programs for problem solving. 30 hours.

5. Group Methods, Beginning Level. Content: Use of groups in meeting needs of and goals of members, examine group work skills and techniques to understand group interaction. 30 hours.

6. The Beginning Supervisor. Content: Functions and problems of supervision, staff development through supervision, decision-making, maintaining agency standards and functions. 30 hours.

7. Adolescent Behavior Patterns in Institutional Settings. Content: Personality development, effects of separation, peer relationships, role of substitute parents, group dynamics, problem solving. 30 hours.

8. Behavior Modification for Social Workers. Content: Theory and methods of behavior modification, application of principles to actual cases. Hours of Training: 30.

9. Sensitivity Training-Research and Application to Social Workers and Related Professionals. Content: To acquire and enhance their sensitivity as professionals and as individuals. To acquire knowledge of group process and dynamics, and interpersonal relationships. To transfer and apply the acquired cognitive knowledge to their work situations. 26 hours of training.

Students

The total number of trainees participating in all training programs during 1971–72 numbered 1906. A breakdown of this figure by discipline is as follows: large urban police department personnel-1563; small rural and urban police department personnel-85; corrections—teachers-6; teachers—public schools-18; Street Club Workers-70; State Department of Mental Hygiene (Trainers)-23; Hospital Social Services-15; City Housing and Community Workers-4; institutional workers-38; juvenile services workers-13; public health-2; private practice-2; psychiatrist-1; psychologist-1; State hospital personnel-8; nursing-2; clergy-6.

When viewed from a perspective of 4 years, The Urban Crisis Training Center has made significant contributions to the training of human services practitioners. Through the Center's programs, the School of Social Work and Community Planning has firmly established itself in the community as committed to the continuing education needs of human services practitioners on the urban scene. Requests for training are coming into the Center in increasing numbers, in particular from those programs and agencies which provide services to vulnerable or high-risk populations, such as the ethnic minorities (especially black youth) or those in high priority problem areas (drug abuse, mental illness, and aging).

Program Evaluation

The Urban Crisis Training Center has utilized two sources of data for program evaluation: a questionnaire administered during the final session of the training program and an evaluation group discussion following completion of the questionnaire. In addition, the Director conducts followup contacts witih agency administrators after completion of a training program, to secure additional evaluation data.

The potential for replication of this program in similar settings is excellent, depending upon a number of critical factors, among them: the extent of the commitment by the sponsoring agency, the accessibility of a significant number of human services systems, the recognition by the service systems of the importance of training for all levels of personnel, and the availability of training funds, a pool of trainers, and a project director with a good knowledge of the essential elements of training, program design, and evaluation techniques.

The impact of this program upon the School of Social Work and Community Planning has been significant. During the Center's initial 2 years of operation, the School's administrative policy of stipulating in all school faculty contracts the necessity of participating in the Center's activities by contributing 40 hours of voluntary time during the contract year provided an essential pool of potential trainers during the Center's formative years. This policy is no longer necessary nor in effect. A half-time position has been created for assistance to the director. The responsibility of the continuing education workshops has been delegated to this position, with administrative control being retained by the director.

The program represents a basic and well-tested service approach, which, in essence, is that a program must be responsive to the training needs expressed by service delivery systems or individuals, and faculty must be able to design an effective training program, select the trainers and training methods with the direct participation of the trainees and their administrators, and to hold itself accountable for results. It also holds that an advisory committee must reflect a broad spectrum of representatives from the community, the School, the University, and the training participants, providing a forum for communications and an impact upon interagency interfacing, in addition to serving as a formal vehicle for systematic input for program planning, and that there must be a commitment to the overall program by the administrators of the School. The Center has successfully directed its major effort toward providing a large proportion of its services to the non-MSW practitioner serving within the broad spectrum of human services.

Social Work–Continuing Education

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MH11206 1968–1973

Objectives

Continuing Education activities are aimed at affecting the organizational context within which practice takes place, and in providing opportunities for practitioners and administrators to improve their skills, upgrade their knowledge, and expand the possibilities of innovating inservice delivery. Program objectives are always seen within the broad concepts of social need and the provision of needed services. For this reason, many of the School's Continuing Education projects are oriented towards service system and program change rather than isolated personal or professional development.

Methods and Content

The Continuing Education Program can be understood best as a complex of interrelated projects. These include: (1) short-term skill oriented institutes and mini courses dealing with topics of interest to mental health practitioners, social workers and allied human services workers (generally offered at symposia in Ann Arbor in June, and in other parts of Michigan and the U.S. at other times during the year); (2) conferences, aimed at specified target populations and involving policy issues and new modes of service delivery (in most cases conducted in collaboration with or under contract to a Federal or State agency); (3) locality of agency based staff development programs planned with local advisory groups for purposes of increasing staff or agency capacity to deal with emergent practice problems; (4) Extension courses which provide academic credit in social work, located in 16 communities throughout Michigan; (5) curriculum materials projects that involve collaborative arrangements with agency, government, and university units, and which result in the development of pilot training programs and curriculum materials that have a life of their own beyond that of the project; and (6) consultations, the bringing together of expertise and practice.

The Continuing Education Program has utilized a variety of teaching techniques including use of films and videotapes (often created by the trainee) programmed instruction, etc. It has also explored applications of the Delphi technique to consumer selection of learning objectives. Over the past 3 years, the Continuing Education Program has experimented with a number of conference styles. One, called "Public Policy Dialogues," was a cross between a TV talk show, a teach-in, and a rap session. The program has become a national center for the building and testing out of gamed social simulations for model building and training purposes.

Educational activities are focused heavily on mental health concerns. The 1972 Spring-Summer Symposium included workshops in behavior modification, staff development and training, grantsmanship, interviewing, child care and child welfare, gerontology, and social work in health settings. Content areas are closely aligned with the needs of the service community.

Conferences have been conducted on New Approaches to Family Treatment, Narco-Politics, Mental Health Aspects of Prison Reform, Implication of Research for the WIN Program, Area Planning for the Aging, development of better articulation of State agency policies (across human service disciplines) in order to facilitate coordination at the local level, etc.

Project grants have been awarded in the fields of Gerontology, Vocational and Social Rehabilitation, Manpower Training, Corrections, Youth Services, Developmental Disabilities, etc. A project, currently in the design stages, would call for establishing a Mental Health Skills Laboratory for all Detroit area mental health and drug related agency personnel. It will be in collaboration with the County's Mental Health Services Board.

The projects have focused on problems in mental health, rehabilitation, gerontology, and manpower.

Most of the extension courses involve 30 hours of class time, for which 2 hours of credit are granted. Symposia occur in Ann Arbor in June of each year, and periodically in local communities. They consist of several short-term workshops. The time involved in other project programs and consultations varies according to their requirements (e.g., 2 days to 4 years). Conferences are conducted at times when they are most likely to have impact on the development of new policies or new programs.

Students

Approximately 500 students enroll each term in extension courses. Most are baccalaureate level social workers and others in human services fields. Participants in the symposia are predominantly social work practitioners and mental health workers, with MA's, MSW's, or equivalent training. They work in a variety of settings—family and children's services, State social service departments, mental health agencies, schools, and hospitals.

Other projects and conferences generally involve specific target groups such as staff development specialists, vocational rehabilitation directors, mental health administrators, social work educators, etc. Many are conducted on an invitational basis.

Program Evaluation

Evaluation varies with the programs. Provisions for monitoring feedback and evaluation are built into all the short-term programs. In the projects, evaluative mechanisms are part of the program design. Continuing education staff, social work faculty, and program participants contribute to the evaluative process in a variety of ways. Questionnaires and followup consultations are among the techniques utilized.

Continuing education is a strong and integral part of the University School of Social Work, and has an impact further than the School itself in *its* collaborative efforts with other units in the University such as the Schools of Public Health, Education, Natural Resources, and with the Institutes of Gerontology, Labor and Industrial Relations, and Public Policy Studies. Training and staff development in local and State units have perpetuated their own mechanisms of training as a result of participation in the continuing education activities, and on a national level, projects gain inroads to policy-making.

The program has worked closely with the community mental health centers and mental health boards in the development of short-term workshops, consultations, drug symposia, etc. The Continuing Education Program has become a national resource for the use and development of gamed social simulations applicable in mental health and social welfare settings.

Consultation in Community Mental Health Services

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MH12444 1970–1973

Objectives

The general objective of the program is to improve services to patients and families known to one mental health center, two mental hospitals and approximately 20 community agencies in the areas served by the three facilities (east-central and south-east Missouri), through more effective utilization of manpower, extension of community services, earlier intervention and strengthened followup services.

Specifically, the program is designed to 1) extend skills of selected community mental health center and hospital personnel in provision of mental health consultation, community organization and coordinating services, and 2) extend skills of selected community agency and other care-giving personnel in utilization of consultation and coordinating services and in development of community mental health services.

Methods and Content

The methods utilized include workshops, seminars, and selected field experiences, with analysis and discussion. Content areas include consultation, community organization, and coordination (within a framework of community mental health philosophy and services), planned jointly by project staff and participants. Time sequence: 1) June 1971—4-day workshop (25 hours); 2) September 1971—December 1972—42 seminars (approximately 168 hours); 3) September 1972—2-day workshop (15 hours).

Students

The following disciplines were represented in the total of 69 students who have participated in the program: activity therapist-one; clergy-two; educator-three; health planner-one; lawyer-one; nurse-12; psychiatrist- seven; psychologist-four; rehabilitation counselor-five; and social worker-33.

The degree levels represented included seven M.D.'s, one Ph.D., 45 Master's (or equivalent), 12 R.N.'s, and four A.B.'s. The following is a breakdown of the years of experience (beyond terminal degree) for the program participants: 1–3 years—14; 3–6 years—14; 6–10 years—13; 10–15 years—5; 15–20 years—4; 20–25 years—8; 25–30 years—4; 30–38 years—3. The participants are employed in the following facilities: 13 Community Mental Health Centers; 19 State Hospitals (urban); 17 State Hospitals (rural); and 20 Community Agencies (rural and urban).

Program Evaluation

The following methods are utilized in program evaluation: (1) three instruments based on empirical indicators completed at selected intervals by participants to measure impact of educational experience on participants, with regard to knowledge, attitude and behaviors; (2) one instrument completed by administrators to measure administrative policy/service delivery change of participating organizations resulting from the educational experience; and (3) three instruments to measure preference, relevance and effectiveness of educational methods, procedures, content and physical arrangements as viewed by participants. Most of the data for (1) and (3) have been collected, but have not been analyzed or summarized as yet. The instrument for (2) is being designed.

The potential for replication of the program is good for similar groupings of mental health and community agency facilities and personnel in other localities and regions in Missouri and other States. With modifications in design, time-sequence and leadership, the program could be adapted for National audiences.

Impacts of the program include: improved intra-inter-agency communication, collaboration and service delivery; extension of community services by mental health center and hospital facilities; tentative plans for assignment of some hospital staff on a full-time basis to selected communities in rural areas to provide extensive consultation and community organization services; and planning now underway for organization and implementation of ongoing continuing education activities in the participating facilities beyond the close of this project.

Changes in the training program include: more emphasis on knowledge building and use of resource personnel, with somewhat less emphasis on skills development through systematic use of field experiences; and less dichotomy of mental health and community agency personnel resulting in "oneness" and strengthened peer type relationships with alternating consultant-consultee roles, both as givers and receivers of help.

Major strengths of the program include: good interdisciplinary mix; rich participant combination from mental health center, hospital and community agencies, both in urban and rural settings; sustained interest and low attrition; broad policy decisions made by the project advisory committee, largely representing the Missouri Division of Mental Health; extensive participant involvement in program planning; substantial financial, personnel and equipment contributions from participating organizations for training activities; excellent cooperation/collaboration of all sponsoring organizations. Major weaknesses include: number of changes in administrative personnel necessitating reorientation regarding project design and purposes, with some decreased educational impact on service policy and delivery; program policy and service delivery philosophy are not always consistent with or supportive of continuing education content; and budgetary restrictions.

The innovative approaches utilized in this program encompass a broad range of educational methods including workshops, seminars, simulated exercises, consultation demonstrations, with a maximum utilization of participants' input in both theoretical and practical content.

Continuing Education–Social Work

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MH11666 1968–1973

Objectives

The aim of this program is the enrichment and enhancement of social work practice in mental health, in a variety of roles and functions, to meet national goals and priorities in mental health. Within this general purpose, there are a series of specific goals. These include: 1) identification of the characteristics and continuing education needs of social workers in mental health, 2) identification of appropriate and highly qualified continuing education specialists and related resources, 3) development of educational materials and resources not only for specific programs but for wide dissemination to NASW members and others, 4) preparation of child mental health trainers, and 5) continuing leadership training for social workers in mental health.

Methods and Content

The NASW-NIMH Continuing Education Program has national, regional, Statewide and local components. Programs on the national level include the Leadership Training Program for Social Workers in Mental Health designed to assist in their transition from clinical roles to those of planning, administration, staff development and utilization, and the National Professional Symposium on Social Work Practice and Social Justice, the third to be sponsored by NASW. This national program is further extended by services to chapters and members through consultation, curriculum resources and program development, and financial assistance (grants) for continuing education programs. On the regional level, annual educational institutes are planned and held in the Southern Region. Locally, chapters plan programs designed to meet the mental health educational needs of their members, with assistance from the national office. The third Leadership Training Program is now entering its second year.

Participants

During the first week-long concentrated session or institute, 106 participants were in attendance, plus workshop leaders and advisory committee members, comprising about 45 Caucasians and 55 minority group members. The latter include Asian-Americans, blacks, Chicanos and native Americans. Workshop leaders and Advisory Committee members are also distributed in approximately a 50-50 ratio among majority and minority group representatives.

The Third NASW Professional Symposium

The NASW, with NIMH support, will conduct its first independent Professional Symposium. NIMH and NASW priorities are so allied that half of the "start-up costs" are supported by the NASW-NIMH Continuing Education grant. NASW has more practitioners in mental health settings than in any other field. The emphasis on prisoners, poor people, patients and pupils, their rights and privileges, and social work's partnership with the victimized is certainly a philosophical departure from traditional thinking and practice.

The Third NASW National Professional Symposium was held in New Orleans, Louisiana in fall 1972. The theme, consistent with NASW priorities directed toward the elimination of racism and poverty was "Social Work Practice and Social Justice": The Contemporary Application of Social Justice Concepts to Social Work Practice in Four Systems: Juvenile and Criminal Justice, Income Maintenance, Health and Mental Health, and Public Education.

School Social Work Project

The school social work project is about to publish its report: *The School and the Community*, the role of the school social worker as a systems (school) change agent.

Regional Consultants for Continuing Education

An extension of the project's services to membership and chapters has been the Regional Consultants for Continuing Education programming. There were at least three indicators of the need for expanded services: (1) the quality of the proposals submitted for NASW continuing education grants to chapters, with $20,000 allocated from restricted Research Education Funds of NASW; (2) the quality of consultative services requested from the national office, which, because of staff and budget limitations were able to be met only minimally, and (3) the assessment of the limited opportunities of continuing educational programs for mental health practitioners derived from compilation of regional continuing education programs appropriate for social workers regionally.

With the assistance of NIMH, NASW was able to identify regional consultants with continuing education expertise and NIMH experience to serve the nine NASW regions. Since the regions vary in need, resources and expertise in continuing education, a flexible program is under development. Each regional consultant, with the assistance of national office resources, will develop a program appropriate for his area, based on the needs, resources and expertise in the area. These plans were formulated in November 1972 and the consultants will meet in February 1973 to share their progress reports and to set up evaluative techniques. By May 1973, evaluation and recommendations will be made.

Clearinghouse Function

The national office continues to render services to organizational units and individual members. These range from chapter and State council consultation regarding program development to advising individual members regarding continuing education needs and programming.

The national office continues to compile a regional listing of course offerings for social workers on a regional and chronological basis. A review of this list indicates particular relevance to mental health professionals. Over 2,000 are distributed seasonally.

The National Association of Social Workers has available a Continuing Education Guide for *Family Planning* which can be used by chapters and the NASW membership. The Guides on *Drug Abuse* and *Juvenile and Criminal Justice* have had wide distribution. These Guides are intended as an educational guide for adaptation to individual and chapter usage. Distribution is made to the NASW membership and the availability made known to the public. More than 1,000 copies of each have been distributed.

Programs—Regional

As an indicator of the need for professional continuing education programs, the Southern region continues to conduct annual regional institutes. The most recent was held in 1972 in North Carolina, and focused on influencing social welfare legislation.

Programs—State and Local

In 1971, the NASW policy on financial assistance to organizational units for continuing education was changed from a loan to a grant basis. This reflected both the chapter needs for underwriting, as well as the national office's increased commitment to mental health continuing education. Two State councils and eight chapters were funded with grants.

At its June 1972 meeting, the Board of Directors authorized the use of $15,000 from general funds on a matching grant basis for continuing education programs. The grants will be available for locally planned and implemented activities under the sponsorship of chapters, State councils and/or other organizational groupings. Since most chapters receive more rebate as a result of passage of the dues referendum, chapters are expected to share the program cost. The amount of a grant to a sponsor will be limited to a maximum of $1,500 and related to cost-benefit analysis, i.e., number served, program quality, likelihood of success and spread effect.

Continuing Education for Social Work in Mental Health

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MH11968 1969–1974

Objectives

The overall goals are to provide continuing education programs to social workers and other disciplines working in the mental health areas. Programs are designed for three levels of workers: graduate, bachelor level and paraprofessionals. Objectives of the project include: (1) improving direct treatment skills and knowledge, e.g., in interviewing and group leadership; (2) developing expertise as adult educators; (3) developing expertise as mental health consultants; and (4) improving local community mental health services by way of improving interagency communication.

Methods, Content and Students

The major offerings, by content area, format, and number of enrolled students include: (1) Certificate Program in Social Services—bi-monthly, 4-hour class, 9 months, 72 hours, 60 students; (2) Crisis Intervention Video Taped—Workshop: 9 hours tape plus 4 hours discussion, 200 students; (3) Interagency Communication—3 day workshop, 120 students; (4) Consultation (metro, valley and Eastern Oregon—6 weekly seminars, total 12 hours, 50 students; (5) Introduction to Group Work Program (Salem, Corvallis, Metford)—bi-monthly class, 3 months, 24 hours, 45 students; (6) Implementing Change: Mental Hospital and Community—3 day workshop, 18 hours, 40 students; (7) Educational Skills for Mental Health Practitioners—3 three day workshops over 9 months, 54 hours, 40 students; (8) Interviewing Skills—independent study, 9 hours, number of students unknown; and (9) Gestalt Workshops—one to 5 day workshop, 200 students.

The students' educational levels include social workers, B.A.'s, paraprofessionals, graduates, psychologists, nurses, physicians and education counsellors. Programs offered for graduate level practitioners have been on a multi-disciplinary basis. The majority of students, about 400, have been at the graduate level; about 300 have been at the Bachelor's level and about 100 at the paraprofessional level.

Program Evaluation

The program uses a number of evaluation approaches: before-after testing of knowledge of content area, participants' evaluations of program including their satisfaction with offering, and identification of changes in systems which can be directly attributed to the continuing education offering. The Project Director, evaluator, and trainers determine the methods of evaluation.

The Project's impact on the community is most apparent in programs which focussed on improving graduate level professionals' skills and knowledge in facilitative services, e.g., consultation, adult education and interagency communication. These programs have resulted in closer working relationships of personnel in local mental health agencies, in the development of consortium of adult educators in the State, in a nonprofit child advocacy group in one community, and in the establishment of a statewide institute for professional development. The strengths of the Project administration and programming may also be its weaknesses. Decisions regarding the kind of program offered have evolved from programming by administration fiat to developing programs by community and professional groups' educational diagnosis of their own needs. The strength of this programming approach leads toward more viable, appropriate educational programs; the weaknesses lie in administration, e.g., the additional time required to organize and meet with planning groups and to select appropriate trainers to develop a curriculum and learning format which will best meet the defined educational needs.

Extension Center in Social Welfare

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MH11150 1968–1974

Background and Objectives

Continuing Education in Mental Health is a component of the Graduate School of Social Work of Rutgers, the State University of New Jersey, and has a reciprocal relationship with the Extension Center in Social Welfare which is an integral part of the University Extension Division. The staff consists of a Coordinator with the rank of Assistant Professor and one full-time secretary.

The broad objectives of Continuing Education in Mental Health are: (1) to develop and provide continuing education programs for professionally educated mental health personnel in order to keep them abreast of new trends and developments and to broaden and sharpen their practice knowledge and skills; (2) to develop and provide continuing education programs for mental health personnel without professional education who are performing mental health functions at all levels of practice in order to introduce them to fundamental mental health concepts and to enhance their practice capabilities; and (3) to develop and provide programs in continuing education for personnel in related professions and occupations whose functions include mental health components in order to enhance their understanding and capabilities related to their mental health functions.

Special attention is directed to: (1) the establishment of program components aimed at expanding and upgrading knowledge and skills of mental health specialists and trainers; (2) the continued offering of programs which focus on meeting the mental health needs of the poor and underserved minorities; and (3) the development of a program component for administrators and policymakers in order to sharpen their decision-making capacities.

During the past 4 years, the program format has changed from an emphasis on 8- or 10-day session courses as the primary vehicle of instruction to an emphasis on intensive, short-term, low cost didactic programs which can be offered in local areas. The content focus is mainly on specific practice techniques (the "how to") within a particular field and less on the theoretical stance of the field.

Program Components

Annual conferences are designed to expose 200–500 participants to the theory and practice techniques of a particular area selected for emphasis. The 1972 conference, "Working with People in Crisis," focused on the use of crisis intervention techniques in mental health and mental health related settings. Conferences are attended by personnel from public and private social agencies, mental health and health settings, juvenile and criminal justice systems, rehabilitation settings, schools and colleges, and churches and religious organizations.

The "Traveling Institute" is an intensive, 1-day didactic experience employing one, two or three resource persons. The cost is low, the meeting place is local, and 25 to 50 students are reached per day. The same institute is offered a number of times with the content being adapted to the educational and setting needs of each location. Traveling Institutes may focus on such topics as: "Mental Health Worker and Pharmacology," "Working with Children in Crisis," "The Crisis Group," and "Counseling the Black Family."

Courses of 8–12 sessions are offered in cooperation with the Extension Center in Social Welfare. The courses are offered throughout the various campuses of the University—in Newark, Camden and New Brunswick, New Jersey. Examples are: "Child Care in an Institutional Setting," "Social Work with the Chronically Ill," "Laboratory in Group Dynamics," etc. Classes are limited to 25 participants.

Consultation is regularly provided to requesting agencies by the coordinator.

Program Evaluation

Evaluation of every institute, course, and conference by participants and planners is built into the program. The results of the evaluations are incorporated into future programs and program alterations. Open-ended and pre-coded evaluation forms are designed for each activity to measure how effectively program objectives are met, and to get feedback from participants on continuing education interests and needs. The results of evaluations are shared with appropriate committees, who actively participate in assessing the total program.

As a result of our program, many course participants received promotions and/or pay increments from their employers; others were inspired to matriculate in degree programs. Some child care institutions developed budget lines for training purposes and revised institutional policies.

Advisory and Planning Committees

In order to guarantee consumer and community input in program planning, two standing committees have been established. The first is a statewide committee consisting of representatives from various levels of practice, including students and consumer groups from fifteen different mental health related settings. The second Committee is the Faculty Continuing Education Committee of the Graduate School of Social Work, which consists of one student and four faculty members representing various school programs. In addition to the standing committees, there are special ad hoc committees whose members are not necessarily members of the other committees. The function of the ad hoc committees is to help with the creation, planning and evaluating of program components.

Continuing Education in Social Work Mental Health

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Objectives

The basic intent of this program is to plan, develop and conduct a high quality Continuing Education Program in Social Work Mental Health. Since the time the program started, the needs of this county's mental health system have changed considerably. Perhaps it is more accurate to say that the perception of needs by many of the decision-makers has changed. This means that the specific educational requirements that can be met through continuing education have correspondingly changed in content, in priority, and in who requires continuing education.

The related major events which have affected these perceptions of social work mental health continuing education needs included a major evaluative research of all mental health services in San Diego County completed in June 1972; other completed research reports pertaining to specific vulnerable populations and reformulations of specific delivery systems; the increased self-organization (politicization) of the Asian Americans and native Americans, and the intensification of demands by Chicanos and blacks for real changes, not superficial ones, in the administration and delivery of human care services; and the emerging new decision-making network in social services. The resulting new assessment of human needs calls for reformulation of programs and the re-education of persons to conduct them.

The first basic educational task of the Continuing Education Program is to map this terrain of new decision routes, rules and processes; and educate the large body of interdependent agents now within the system as well as the many consumers who seek to participate in future decisions on distribution and utilization of available resources for human services.

The four components of this program reflect the general approaches: (1) Educational Assessment Programs; (2) Educational Programs; (3) Educational Materials Development Program; and (4) Information Service on Other Related Educational Programs.

Content and Specific Objectives

Task groups have been established to determine the specific objectives, courses, and trainee target groups in five content areas:

1. Mental Health Task Group: (a) New Roles for Consumers, Citizens and Providers in Comprehensive Health Planning; (b) Developing Relevant Services to Low Income Groups; (c) Alternative Approaches to Existing Mental Health Services; (d) Sexual

Prejudices About Women's Role Affecting Theoretical Assumptions in Therapy; and (e) Development of Program Evaluation Models and Procedures.

2. Child Care—Youth Development Task Group: (a) Program Models Implicit in, and Funding Patterns for, Child Care Programs of the Federal, State and Other Sources; (b) Training of Staff and Volunteers for White Alienated Youth Programs; (c) Problem Identification and Program Development Pertaining to Youth Employment, Criminalization, Family Relationships and New Life Styles.

3. Minority Group Task Force: (a) How to Educate Others About Ourselves on Minority Needs, Priorities, Programs and How They Affect the Community in General (a series of courses for minority providers of human services); (b) Participation to influence minority input into the other four task groups.

4. Social Planning and Action Task Force: (a) Data Collection (for updating staff on sources and use of data); (b) Data Analysis (for updating staff on uses of electronic techniques and other developments); (c) Social Analysis (analysis of power, institutional authority, ethnic influence, consumer perception and reformulation of social needs); (d) Agency versus Community Needs; and (e) Management Training for Planning Agency Staff.

5. Staff Development Task Group: (a) Education for Educators; (b) Administration and Management in the Social Services and Mental Health; (c) Review of the Social Welfare Systems (changing concepts, goals, rules and expected outcomes); (d) Understanding of the political and legislative processes related to social services and mental health; and (e) Goals and Methods in Institutional Change.

Methods

The methods within the four components are:

1. Educational Assessment Programs: individual self-analysis of aspirations and areas of needed improvement; and institutional analysis.

2. Educational Programs: courses; institutes; seminars; workshops, singular or in series with some problem-reduction task; lecture series for various publics on and off campus; staff development programs; board development programs; faculty development programs; and linking consultees and consultants.

3. Educational Materials Development Programs: selecting, gathering and putting into usable form the foundation principles, concepts, techniques and issues in a range of specific areas; testing and modifying materials and teaching others how to use them; developing ways of distributing and using these educational materials; stimulating research and collaborating with research centers on both development of knowledge and testing of applications; and maintenance of rosters of competent teachers, discussion leaders and other resource persons for continuing education.

4. Information Service on Other Related Educational Programs: close cooperation with the other continuing education programs of the community; information file on related career development information; and information file on related doctoral programs for those in continuing education who want to consider doctoral studies.

Program Evaluation

An evaluation program is being formulated which is composed of four interdependent assessment areas: (1) individual learnings, improvements of capacity and behavioral changes; (2) institutional or organizational learnings, improvements of capacity and behavioral changes; (3) community learnings and specific social changes; and (4) program quality guidelines. The individual learnings can be sought and tested in the realm of concepts, relationships among concepts, choice of utilization of concept in specific problem situations, attitudes, and certain skills.

The following assessment techniques are being considered: (1) standardized paper and pencil tests on fact, attitudes, opinions, and nonstandardized areas on what they say their choices of practice decisions and action strategies would be in hypothetical situations; (2) assessments of task-accomplishment in workshops in view of preworkshop criteria established by experts on relative best approaches to a complex problem situation; (3) group self-assessment at end of learning experience on knowledge, attitude and skill changes stimulated or provided by the particular learning experience; and (4) tracking and recording over time of the observable and reported changes of program and administrative decisions or organizations whose staff and/or board members have participated in staff development or board development activities within this Continuing Education Program.

Extended Education in Mental Health

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MH12888 1972–1974

Objectives

The Division of Continuing Education of the Graduate School of Social Work at California State University, San Jose, has been established to help meet the educational needs of individuals and organizations engaged in promoting the social welfare of others. Within this framework the Division places particular emphasis on continuing education which addresses itself to the social welfare needs of the Spanish-speaking community.

In fulfilling this purpose the Division will develop knowledge, skills, and attitudes which will: (1) enable paraprofessionals and professionals in health, social welfare, and related fields, to increase their effectiveness in performing social welfare tasks; (2) enable community organizations to increase their effectiveness in meeting the health and social welfare needs of the community; (3) enable the community to establish a positive rapport between and among its ethnic and racial groups; (4) enable people to enhance their abilities to plan, direct and live with social change and; (5) enable trainers and educators to increase their effectiveness in designing, implementing, and evaluating human resource development programs.

Methods and Content

Three major learning activities are scheduled for 1972–73. One activity includes four workshops to be conducted in conjunction with California Social Workers Organizations, Inc., Asilomar Conference. The conference is geared toward the continuing education needs of those persons working in the social welfare fields. In one of the workshops, "Working with the Spanish-Speaking Client," individuals will acquire knowledge of the Spanish-speaking individual in the United States—his history, his view of assimilation, the role white attitudes play in creating and perpetrating second-class citizens, and value systems that might provide a theoretical basis for developing solutions. In another, "Techniques for Assessing and Designing Training Programs," persons interested in designing and planning staff development programs will be able to learn how to assess the needs of their agency personnel, design training programs and implement them. Emphasis will be on the needs of each individual trainer. In the workshop on "Methods and Principles of Organization Development," individuals in middle and upper management positions will learn how to better utilize their manpower through the techniques of goal setting, analysis of performance gaps and analysis of training gaps. In the fourth workshop, "The Role and Use of the Consultant," supervisors, line social workers, and administrators of social programs will learn the roles of the consultant, and the nature and scope of consultation as a method of social work practice. In addition, they will learn the process of consultation and evaluation of consultation services.

A second learning activity, "Social Service Needs of the Chicana" (Spanish-speaking woman), will be a 3-day workshop to bring together professional Chicanas, student Chicanas and low-income Chicanas to: identify needs of the Chicana at each of these levels; assess the resources presently available to meet some of these needs; determine the nature and scope of unmet needs in existing service delivery systems; and develop strategies for fulfilling unmet needs.

In the third learning activity, "Planned Change Approach to Mental Health," the participants will include community mental health workers, mental health professionals, and Chicano grassroots leaders. The principal formats are workshop, directed study and clinics. The content is being developed in conjunction with DCE staff, participants, school faculty and the Advisory Committee. Workshops will be conducted around each of the four major Planned Change Phases—

Analysis, Design, Implementation and Evaluation.

Program Evaluation

In order to assess the effectiveness of this continuing education program, several methods will be utilized. The division will have a postmeeting evaluation and there will be a followup survey of activities. Other methods of evaluation are in the process of being developed by the continuing education staff in conjunction with the advisory committee, the social work school staff and the university.

The advisory committee of the division is composed of representative groups of the community (trustees, social agencies working with large Spanish-speaking populations, grassroots organizations and other related departments within the university system). The committee will help assess the impact of the programs on the groups with whom they work.

The innovative features of this division are its emphasis in three areas: on Spanish-speaking communities, on the development of viable training activities to improve and enhance the knowledge and skills of those individuals who train providers of health and social services, and on community participation in the planning, implementation and evaluation of continuing education programs.

Continuing Education Program

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MH11195 1968–1974

Objectives

The goal of the Continuing Education Program of the School of Social Work is the improvement of the delivery of mental health services through the enhancement of mental health knowledge, skills and attitudes of mental health practitioners at all levels of formal and informal educational experience. The program wishes to reach two major groups—social workers with MSW's and individuals working in social agencies who do not have the MSW. This includes persons with A.B.'s and those with less than an A.B., as well as members of other mental health disciplines with equivalent professional preparation and practice experience such as nurses, psychologists and teachers.

More precisely, continuing education offerings are designed to meet the needs of: (1) professional and paraprofessional workers (whether or not indigenous) in direct contact with the more seriously disturbed or more severely disadvantaged in our communities—the ethnically or socially handicapped, the youthful drug users, the poor, in and out of ghettos, and others; and (2) persons within those agencies whose respective key positions (administrators, trainers, supervisors, consultants) bring them in contact with a sizeable number of persons who are charged with helping others.

More specific objectives include: (1) aid to the mental health practitioner to develop new and different ways of viewing and using a variety of service models; and (2) assistance to personnel at various levels in helping agencies to understand and use mental health principles in coping effectively with the changes they face directly, and with the changes in which they wish to involve the consumers of their services. Moreover, it would be expected that a byproduct of continuing education directed at dealing with such immediate and urgent objectives could be instrumental in aiding the paraprofessional and/or indigenous aides to strengthen their self-concept and to work within their capacities to maximize their potential as helping individuals.

Methods and Content

The Continuing Education Program utilized modern adult continuing education approaches. Included are small seminar-type groups, workshops and institutes varying from 8 to 16 weeks. Included along with the lecture and seminar approach, are audiovisual aides, simulation and demonstration of techniques by instructors and problem-solving exercises based on participants' live practice experiences. An opportunity to prepare for an offering by suggested prior reading, a briefly written vignette of practice problems encountered, a problemsolving task or a participant's statement of expectations and learning goals may be requested in advance of a course or during a course for maximum learning. The majority of the workshops are held during the summer for 2½ to 5 full days, with emphasis on the latter. Spring offerings are scheduled for evenings. The fall semester is primarily a planning period; however, during this period as well as throughout the year, the special programs for various agency, staff and community groups are cooperatively developed upon request. Future plans are to offer evening courses in the fall.

Offerings include content areas such as material dealing with group process, family therapy, crisis theory, use of indigenous aides, work with community groups in advocacy roles, work with minority ethnic groups and individuals, newer theories of behavior and practice, newer ideas about organization and delivery of services. Also included is the need for foster parents to recognize and understand the mental health problems of children in institutional settings, mental health concerns of the elderly, mental health needs of adolescent youth. Courses in supervision, administration and drug abuse are included.

From the various advisory committees, community agencies, and from the reactions and suggestions of persons who have been participants in one or more of the continuing education opportunities, have come a number of suggestions as to content, instructors and format for these future undertakings. These suggestions are wide-ranging; from focusing on "free clinics" dealing with young people (particularly in relation to drug abuse, family planning, and venereal disease), to work in residential treatment centers, to focusing on administrators or decisionmakers in agencies, or concentrating upon helping indigenous aides to carry more effectively the responsibilities delegated to them. Along with these the program places emphasis on mental health needs of ethnic minority groups in the ghettos and barrios, community mental health, crisis intervention with regard to drug usage and other social-psychological problems, modalities of group and family treatment, and new technology in service delivery—in that order.

Although a range of subjects have been offered, all have in common an emphasis on mental health concepts in administration of social welfare programs, and the delivery of services.

Students

The total number of trainees has been approximately 800. The majority of trainees have been and are social workers. The educational and experience background varies each year as well as for each offering. During the last 2 years approximately 50–70 percent have been MSW's and roughly 30–50 percent are BA graduates, 10–20 percent represent those employed in various paraprofessional capacities. The number of years in the field varies, for a large number of persons enroll shortly before or after a change in agency setting or job function.

Persons from the following disciplines and fields also have enrolled in the program: nurses, rehabilitation counselors, psychologists and law-enforcement personnel. There is still a large number of potential trainees available from these and other disciplines, particularly nursing, psychology, and education. The Continuing Education Program hopes to identify faculty from these and other disciplines working in the mental health and social service fields, and to seek joint offerings with other schools and professional associations to facilitate this.

Program Evaluation

The general patte[illegible]ring the life of this project has been t[illegible]aluate each formal undertaking, wheth[illegible] short institute or a long course. The pu[illegible]se of the evaluation has been to gain information about what is helpful or not helpful to those who enroll in the offerings, to learn what kinds of information appear to have usefulness, to identify the formats most conducive to learning, to gain information about areas of learning needs, and to involve the enrollees in the assessment of the offerings and to use their reactions—whether positive or negative—in the planning of subsequent offerings.

In 1970–71, a team of six student evaluators, under the guidance of a research faculty member, conducted a three-phase study of the Program's course offerings. The team: (1) compiled and analyzed questionnaires returned by all course participants; (2) developed, distributed and analyzed the responses to a followup evaluation questionnaire sent to a random sample of participants; and (3) interviewed a purposively selected sample of agency administrators who (a) sent, and (b) did not send staff to Continuing Education courses. This three-phase study was conducted in an effort to obtain systematic feedback and to obtain information that could be used to improve the effectiveness of the program.

Based on the evaluation team's findings, a revised "end of course" questionnaire was developed and administered to all participants in the various spring and summer 1971 offerings.

The review, tabulation and analysis of participant responses to program offerings of spring and summer 1971 were reported in June 1972. This evaluation was conducted by a second year MSW student under the instruction of the research faculty member who had instructed the previous team of student-evaluators.

The above-mentioned questionnaire was revised to a 22-item instrument which serves as a useful administrative tool in quickly assessing major interests and needs of participants.

As part of the process of clarifying and operationalizing overall and specific Continuing Education Program objectives, evaluation information is shared with the advisory committees (consumer agencies and faculty). In this way, it is hoped that both general and specific objectives can be sharpened and focused so that qualitative and quantitative indicators can be used in future evaluations.

The June 1971 evaluation report indicated that administrators felt the potential for impact was enhanced with closed institutes in which course offerings were designed specifically on the basis of an agency request, with meaningful agency involvement in the course design. The above report also indicated that when participants are selected to attend the program on the basis of agency needs rather than on the particular interest of the participant there is a greater spread effect or expectation of this effect through the dissemination of new knowledge by various formally planned methods. The June 1972 report suggested a spread effect resulting from trainees' particular interests which were indicated by their responses to the questionnaire.

In an effort to incorporate suggestions from current and potential trainee groups as well as from various advisory and research and evaluation conclusions, some of the following changes are: longer courses in the evening with more suggested preparation on the part of trainees before initial course meetings. The program has become more explicit in its planning and expectations with trainees and their agencies regarding participation for trainees receiving stipends. This includes: minimum attendance expected, agency and trainee planning for reporting back and means of using new learning; stipulate that stipend recipients represent the priorities set by the Continuing Education Program.

During the last 2 years a balance between public and private agency participation has been achieved in contrast with the earlier predominating public agency, particularly public welfare enrollment. The drop in enrollment from this latter group was due largely to a decrease in agency financing for attendance.

A major strength of the program has been its ability to meet its own objectives, both in the minds of trainees and program personnel. The program has gained a reputation for its high quality of instruction, content, timing, usefulness and for seeking the input from the various constituencies of the program. Another strength and unique feature of the program is the small faculty advisory committee which has offered special advice and guidance with respect to such areas as curriculum, educational resources, research and evaluation. This committee includes a broad representation of the school's faculty. The program also has an explicit evaluation procedure which takes into consideration various points of view in assessing its effectiveness. There are continous attempts to refine this procedure in order that a clearer basis for determining the direction, scope and content of future activities of the program may be achieved.

As a means of enhancing program effectiveness the program encourages agencies to build in formal mechanisms to enable staff who attend courses to report to others in the agency who are unable to attend. This is more readily acceptable by agencies which contract with the program for special closed offerings or where staff attendance is agency financed.

The program expects to expand the interdisciplinary efforts of the Continuing Education faculty resources as well as recruitment efforts for trainees from other mental health and related disciplines. To this end the program will be continuing efforts toward cooperative and joint offerings with other schools within the University and other professional associations as well as considering the feasibility of increased number of credit offerings.

Social Work–Community Mental Health

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MH12789 1972–1975

Objectives

Social Work-Community Mental Health is an NIMH funded project of 3-year duration conducted by the Southern Regional Education Board. The general objective of the project is to involve the 20 schools of social work in the SREB region in a faculty development process via workshops, institutes and task forces designed to institutionalize a community mental health curriculum. The process will involve the utilization of expertise within the schools to develop a definition of community mental health, develop a community mental health curriculum, and evaluate the current curriculum in each school to determine how community mental health as defined can be implemented. From time to time, consultants with special skills necessary to establish the community mental health perimeter will be used. Both students in the schools of social work and community mental health practitioners will participate in the developmental activities. This is to assure that a realistic perspective is maintained. Base line data from each school are being collected regarding specific curriculum now existing as core-sequences. This base line data also document where each school is regarding a community mental health curriculum.

Methods and Content

Training methods consist of short-term, 2 to 3-day workshops, institutes or task force meetings. Consultants with special competences in specific content or process areas will be used as requested by the various task groups. Schools in the region will be divided into four sub-geographical areas. They are Texas and Arkansas (five schools); Louisiana, Mississippi and Alabama (four schools); Florida, Georgia and South Carolina (five schools); and North Carolina, Virginia, West Virginia, Baltimore and Washington, D.C. (six schools). This geographical designation is to aid schools with limited travel budgets to be able to participate in the activities. These groups will also constitute the task groups needed.

Specific content areas will include recommendations for teaching such concepts as: advocacy, entrepreneural management and community development in schools of social work. Other subject areas will be education, (including the learning theory), community planning, community process, prevention and promotion in mental health, outreach, short forms of intervention, rehabilitation of the mentally ill and retarded, working with people with special mental health problems, such as alcoholics, drug users, etc.; new manpower models and models for supervision, program planning and evaluation, setting goals and objectives for delivery service, administration and management, and opportunities and justice for all minorities. The time sequence and total number of hours spent in each activity or each subject area will be determined specifically by the faculty of the participating schools, since this kind of participation will lend itself more to the development of a community mental health curriculum in each school.

Students

The number of persons participating in the training program will depend upon who is identified from each school, by the dean, to participate in the process. Initial recommendations were that faculty with faculty development responsibilities and/or community mental health competence, because of previous experience or relevant teaching involvement, would best suit the objective of the project at the first workshop held on November 13, 14, and 15, 1972.

Program Evaluation

Training in community mental health has not been offered previously by schools of social work. Therefore, community mental health is defined from the perspective of a particular geographical area. Much too often, a psychiatric framework is reflected. The base line data discussed under the objectives will be the major tool to determine movement toward a mental health curriculum in each school. With this basic curriculum information, it will be a routine process to periodically send to schools a questionnaire requesting any curriculum changes based on the activities of the project. The faculty who participate in the project activities from each school will also be polled via questionnaires to determine any changes toward a community mental health curriculum. Presently, evaluation techniques are being developed by the project director. As the project proceeds, however, the project participants will participate in the development of an evaluative technique. Students will be a very important part of the process.

This is a unique project because it provides a structure through which community mental health can be uniformly defined throughout the SREB region and appropriate steps taken to institute a mental health curriculum in each school. There is also the opportunity for community mental health to be explored from rural and urban perspectives since schools within the region fall within both rural and urban areas. There are great possibilities for this project to be replicated in other areas.

Today, with only 2½ months activity in the project, faculty have exhibited considerable interest in community mental health and have expressed concern about how such a curriculum can become a part of the schools' core sequences. Since the initial workshop November 13, 14, and 15 for project planning, there have been a number of inquiries from faculty participants about future project activity scheduling. Suggestions have also been made for future activities. The community organization faculty in schools in the region also held a meeting on November 25–26 in New Orleans. They are interested in considering community mental health in their curriculum development since these two areas are very much related.

The major weakness in this project is that there are not sufficient funds available in the project to supplement some of the schools' inadequate travel budgets. The greatest strength of this project is that SREB, through its previous interest and work with social work education, is able to provide a structure through which participatory developmental activities can occur. This is an innovative approach to continuing education because the faculty from the schools will be used as the project's resource persons. This emphasis provides a developmental base that encourages faculty participation as well as concomitantly structuring in a realistic perspective to community mental health in schools from a local as well as southern rural perspective.

Continuing Education–Social Work

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MH11640 1968–1973

Background and Objectives

For the past 40 years, a continuing education program, with sessions in the fall, spring and summer semesters, has been an integral part of the total educational program of the Tulane University School of Social Work. With the general objective of updating knowledge and upgrading efficiency, it has developed and offered a wide variety of courses related to the many disciplines within the fields of health and social welfare.

Specific implementation of the program is based upon an ongoing process of discovering and evaluating emerging needs. This function is performed by the school's Continuing Education Committee which coordinates the recommendations made by faculty, alumni, students, past and present consumers and by local and regional agencies. On the basis of these recommendations, priorities are established according to the urgency of need within a specific target group. The present program is directed at professional and paraprofessional community mental health workers, psychiatric social workers, child development and child care center workers, corrections personnel, drug abuse program directors and counselors, mental health therapists, rehabilitation counselors, directors and administrators of social service agencies, new faculty in Schools of Social Work, and agency staff teachers in inservice training programs.

Methods and Content

The didactic material of the continuing education courses is newly developed theoretical knowledge and practical skills which are pertinent to the improvement of efficiency. Specific content found to be of current value has encompassed: 1) reality therapy as applied to problems in social work, corrections and counseling activity; 2) family interviewing and treatment; 3) use of a group to involve individuals in deepening sensitivity to themselves and to others; 4) social treatment of troubled youth and youth with special mental health problems; 5) personality and environment in human behavior; 6) clinical strategies in serving the mentally ill and retarded; 7) team leadership; 8) social work practice with families; 9) elements of human behavior and therapeutic intervention; 10) the application of behavioral principles to social work practice; 11) manpower strategies in the utilization of nonprofessionals in social work; 12) group treatment; 13) administration of organizational change in social welfare; 14) alternatives to traditional supervision; 15) new programs, strategies and techniques in corrections; 16) administrative aspects of licensing; 17) family day care licensing; 18) theories of adult learning; and 19) the development, design and sequencing of social work education curricula.

The teaching methodologies vary according to the type of material and the composition of the target group. Generally, the seminar format is employed. Presentation of material is followed by discussion. Where applicable, various group methods, such as role playing, are utilized. Use is made of audiovisuals when they contribute to the teaching objective.

Seminars and workshops in the Summer Program are usually scheduled for 5 days, 3 hours a day; other seminars during the year vary in length. The Summer Preparatory Session conducted for social work educators, that is, for teachers in Schools of Social Work and for staff agency inservice training teachers, lasts for 4 weeks. In addition to the daily, 3-hour seminar session, several hours per week are devoted to library work, to field practicum experiences and to designing and developing curricula and program models.

Participants

Most participants are social workers with Master's degrees. Ten percent have done advanced work beyond the Master's level. Almost all have had substantial experience in social work practice. The main categories represented in recent sessions have been directors and personnel of community mental health centers, of child care and child development centers, of maternal and child health services, and of Public Welfare Agencies, plus corrections personnel and social work educators. It is anticipated that future sessions will draw a large attendance from the population of potential trainees, among which are: direct service personnel in mental health agencies; professionals and paraprofessionals employed in narcotic addiction and drug abuse rehabilitation programs; counselors and therapists in alcohol programs, management personnel in child day care centers; administrators, program planners and evaluators; middle management personnel in community mental health centers; and minority group personnel employed in neighborhood health clinics, ghetto area drug abuse programs, and neighborhood child care and development centers.

There has been a steady increase in the number of participants. If the present rate of increase continues, approximately 500 from all sections of the country, will be attending in 1973.

Program Evaluation

The short-term workshops are evaluated on the basis of effectiveness of the student recruitment procedures, of the timeliness and suitability of content, and of the aptness of teaching methodologies. Some evaluation is made of the students' learning and satisfaction with the workshops, most of it on an informal basis or by an individual instructor. A formal system is in the process of development, whereby the effect of program attendance on the students' actual work situation can be gauged. This will probably take the form of a questionnaire-survey to obtain judgments on the effect of workshop attendance on efficiency, comparing performance before and after participation in a workshop. Evaluation of the 4-week teacher Preparatory Session is both formal and extensive, these participants are only requested to fill out a questionnaire but, after an interval of time, some are invited to return for a 4-day session during which the Preparatory Session program is reviewed and then judged on the basis of actual and potential utilization.

A feature that has had a significant bearing on the development of Tulane's Continuing Education Program is a faculty composed of leading authorities who are drawn from all parts of the country. Adherence to this long established policy of annually making nationally recognized experts available is a distinguishing element that continues to attract the social work practitioner. Since the program is now beginning to attract more and more personnel who have leadership roles as supervisors, managers, program planners and teachers, its unique potential for extending the utilization of its sessions will receive more concentration during future planning.

A plan to make available interdisciplinary courses in other divisions of Tulane University; namely, the Medical School, the School of Public Health, the Law School and the Graduate School of Business Administration is to be implemented in the future. Participants in the summer teacher Preparatory Session are going to receive an extended opportunity for study of Tulane's Student Training Center system and for field practicum experiences. The same opportunity may be given to those who attend the workshop sessions if it becomes possible to lengthen the workshop period beyond the 5-day period now used.

Faculty Development
Minority Content in Mental Health

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MH11549 1969–1975

Objectives

The program's primary purpose is to increase faculty competence in minority ethnic content in the social work curriculum and the educational process. The objectives are designed to increase the faculty's ability, both individually and institutionally, to deal with this subject in terms of the differential roles and responsibilities of deans, curriculum committee chairmen, and selected faculty, both class and field. The objectives will enable the participants to extend and deepen their knowledge of comparative human behavior and developmental mental health practices and needs across ethnic group and cultural boundaries, identifying those minority ethnic concepts which have specific relevance for mental health education and practice. The program also seeks to strengthen the curricula of the schools of social work in the western region in this important content area.

Methods and Content

A variety of means will be used to achieve this program's objectives. The plans are to implement the program with a series of workshop and consultation activities involving a sharing and exchange of information representing the needs and experiences of mental health agencies and the schools of social work in the region; the development of position papers on varied aspects of this field; and incorporation of inputs from the several minority curriculum projects being carried out across the country. These workshop-centered activities will be supplemented by followup consultations to school faculty and agency staff by one or more members of an interdisciplinary panel of resource people developed for this purpose.

Students

The primary trainees will be deans, curriculum chairmen, and selected faculty from the 13 schools of social work in the western region. Important indirect "consumers" (participants) are selected graduate students in social work and community and mental health representatives, including the patient or client population-at-risk.

Program Evaluation

Deans of the schools of social work, faculty and students will all be involved in the evaluation process. Faculty workshops and conferences have been assessed through end-of-workshop questionnaires and through followup letters sent to each participant after 6 months have elapsed. This content has been helpful and generally positive in terms of program objectives. The response to these evaluative undertakings, however, has been disappointingly similar to general experience with questionnaire returns in other areas of data collection. There has been a 50 to 60 percent return which is a disappointing ratio, considering the personal contact and presumed bond generated by the workshop experiences with the respondents.

PART 6

CONTINUING EDUCATION FOR INTERDISCIPLINARY TRAINING

Continuing Mental Health Education

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MH11100 1967–1974

Objectives

The program seeks to promote an active and enlightened dialogue between specialists in the mental health field and persons, both professional and paraprofessional, who desire to relate mental health concepts to their public duties and responsibilities. The program is designed to facilitate a broad exchange of information and experience and encourage adult educational activities that will benefit both mental health specialists and the general public and create a better environment for preventive mental health.

Concepts and methods important to preventive mental health and the best in new research information are emphasized as a means of changing student attitudes and behavior in human relations and problem solving.

Methods and Content

About one-third of the programs with students are devoted to informal lectures, panel discussions and film presentations. The remaining time is devoted to interaction of students and leaders in small (10 to 12) professionally-led groups. Assigned outside reading provides students with further stimulation and helps extend and reinforce the formal part of the learning experience.

Curriculum content is developed in close consultation with representatives of consumer groups of students to meet the specific mental health needs and concerns of both groups. The curricula have been designed to meet, for example, the needs of teachers concerned about the affect of racism and poverty on the mental health and educability of children and youth; counselors and caseworkers concerned about their own attitudes about human sexuality and the why and how of counseling youth about sex; and professionals (doctors, nurses, chaplains and social workers, etc.) in medical care settings wishing to be more effective in their work with dying patients and their families.

Most continuing education programs involve 24 to 30 hours of interaction workshops among 40 to 60 students, plus professional group leaders, lectures and panel discussants. These are planned as 3-hour workshops once weekly over an 8 to 10-week period. A few programs to meet special concerns or followup needs of students are designed as 1-day conferences or 1-day workshops.

Students

Over the past 5½ years, students have included teachers from public and private schools, school superintendents and administrators, clergymen, religious education directors, social workers, nurses, physicians, guidance counselors, poverty workers (from Head Start, the Model Cities program, Title I, O.E.O., and the R. I. Welfare Rights Organization), school guidance counselors, lawyers, and funeral directors. Some programs are designed for a homogeneous group and others for heterogeneous groups of professionals and paraprofessionals who have similar needs and concerns.

The Center receives many more student applications for admission to its programs than can be accepted because of budget limitations and overcrowded facilities.

Program Evaluation

Questionnaires are completed by students before and after each workshop series. Student expectations, reactions and attitudes help reshape and improve a particular program if it is repeated, and aid, where advisable, the planning of followup work with students.

Data from two major evaluation studies are available. These studies were planned and carried out with the aid of a consultant who is a research psychologist.

The program has been much in demand and has gained considerable recognition from colleges and universities, health practitioners and the general public. Local committees, religious groups and various social agencies have imitated our training methods and developed new training programs modeled after the small, group-centered pattern used at the Butler-Bradley Center.

In Rhode Island the program is innovative because: 1) students assist in planning curriculum and related areas; 2) the professionally-led small group method at the heart of the program stimulates the personal growth of students through the informal, intimate exchanges of feelings, attitudes and problems—personal or professional—as these relate to the curricula and themes of various workshops; 3) the curriculum is flexible so that, during the process of workshop development, changes and additions can be made as students and leaders recommend; and 4) no other educational program for mature adults exists in the State to bring mental health specialists and professionals and paraprofessionals from related fields together to emphasize and share problems related to preventive mental health.

Continuing Education–Psychiatry

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MH07966 1962–1974

Background and Objectives

The Center is a multiagency, interdisciplinary continuing education program operating as part of the California State Department of Mental Hygiene. The basic goal is to increase the level of knowledge and improve professional practices in community programs concerned with mental health and mental disorder (including mental retardation) in Northern California. Subgoals are to: (1) train employees of mental health and other human service agencies in processes and techniques not usually emphasized in basic professional education; (2) foster interdisciplinary and interagency collaboration by involving persons with different backgrounds, training and expertise as faculty and trainees in a shared learning experience; and (3) consult with local agencies on the development of inservice training in community mental health and related subject areas.

Objectives of specific activities vary with the content area and target population, e.g., a series of courses on program evaluation prepares professionals with responsibility for evaluation to develop and conduct relevant and viable projects in the context of their own agencies.

Methods and Content

Lecture-discussions utilizing both content experts and practitioners, literature seminars, and simulation exercises are the main methods used to increase trainees' knowledge. Changes in their practice are approached through small group consultation by experts and peers on work-related field projects, role playing of critical interactions with videotape feedback, and trainee-designed and executed projects and demonstrations. Content areas covered include: preventive services and consultation; case management; program evaluation and research; program planning, design and management, and new methods and systems for service delivery. A typical course involves 4 hours of class time weekly in an 11-week quarter, supplemented in some cases by a field work project. For some content areas, courses are organized into three quarter sequences to allow trainees to develop skills more fully and to experience the process of change over a longer time span. Full-time and half-time summer courses, 1 to 2-day institutes and workshops, and supervised field experience are also offered. Trainees who complete an individualized, goal-oriented program of twelve courses receive a certificate as a "Community Mental Health Specialist."

A small core staff is supplemented by a visiting faculty drawn from local educational institutions and service programs. Input from faculty, present and past trainees, representatives of community and State agencies, and expert consultants is used by the staff to develop and modify courses to meet identified needs within the mandate and policies of the Department of Mental Hygiene.

Students

A basic feature of the Center's operations is that trainees are accepted on the basis of their current functional roles. Thus, the student body includes educators, managers, supervisors, practitioners, consultants and evaluators whose prior training ranges from high school equivalency through postdoctoral fellowships. The potential trainee population is limited only by the Center's resources for developing relevant programs and the willingness of human service agencies to release employees for the time involved in travel and training.

In 1971–72, 350 registrants in one or more of 20 courses represented 213 individuals. These included psychiatrists (30), psychiatric social workers (63), clinical psychologists (20), public-health psychiatric nurses (7), psychiatric technicians (19), and 74 representatives of other fields of work such as corrections, rehabilitation, education and administration.

Program Evaluation

Descriptive studies of the student body and basic cost analyses are performed routinely. Trainees evaluate each course at its completion, rating the educational input and achievement of instructional objectives on Likert-type scales. Special followup studies of ways in which trainees apply their new knowledge on the job have been planned but not yet implemented.

Because the Center draws largely on local resources for faculty, and because trainees need not leave their jobs to participate, its design could be duplicated in any geographical area which contains a sufficient concentration of both expertise and service programs within a reasonable distance to justify the provision of core staff, space, and clerical support. The short-term impact of the program results from the fact that trainees are expected to relate their training to their own work experiences and indeed often receive specific help in solving agency problems. Taking a longer view, Center registrants seem to have a tendency to move into positions with program responsibility, thus, an indirect impact on program change can occur to the extent that the models presented have been accepted and internalized.

The greatest strengths of the program are its ability to respond rapidly to current community needs; the part-time, work-related nature of the training provided; the focus on interdisciplinary interactions, and the ability, where appropriate, to provide an organized program of courses to prepare individuals to make changes in their basic professional identification. Related to these strengths are weaknesses. The work-problem oriented design may result in trainees not developing a well-organized conceptual model. A high degree of both individual initiative and support by the employing agency are requirements for successful participation. The multilevel character of the student body can result in some inputs being above or below the level of sophistication or understanding of specific trainees. The lack of a "laboratory" program under the Center's control creates difficulties in testing out new or radically different models of community practice. As a result of the high demand for service, staff time available for evaluation has been limited.

The most innovative aspects of the Center's program are its emphasis on process rather than content and the mix of discipline and educational level in its trainees. Taken as a whole, the flexibility of the operation and the wide range of courses provided by a relatively small and low-budget operation are unusual, if not unique, in the field of continuing education in human services.

Center for Training in Community Psychiatry

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MH10252 1967–1975

Objectives

The ultimate objective of the Center is to influence the delivery of mental health and related services in a positive direction through educational methods of interdisciplinary, interorganizational study, discussion, and problemsolving. Its main function is to provide continuing education for mental health and related programs in Southern California.

The immediate objectives of this program are to provide new knowledge and skill development in those functions in organizations related to planning, development and delivery of mental health and related services, responsive to the needs of communities served. The formulation of Center objectives emerged through surveys, staff discussions, advisory groups, and the constituency (organizations and individuals) served and desiring to be served.

Methods and Content

A wide range of educational methods are used selectively to provide new knowledge and to provide in each course opportunity for its application to job responsibilities and problems identified by participants in their own organizations. Methods include lecture, preceptor-led discussion groups, simulation exercises, and consultation practicum in conjunction with audio, film, and videotape presentations. Participants are actively involved in the decision to select content and methodologies most useful to their learning.

The specific course content areas relate to: (1) processes: mental health consultation and education, community organization, citizen participation, administration, and program evaluation; (2) special target groups: substance abuse, children, and mentally retarded; and (3) special issues: emergency services, planning, legislation, and law enforcement. The decision to provide new education and to expand or drop educational offerings is influenced by the needs of service programs, their staffs, and the community, and by legislative and administrative mandates.

In general, each course represents a minimum of 40 hours of education at the Center. The pattern is usually through ½-day sessions, weekly, over a 10-week period or for a whole week (5 days, 9 a.m. to 5 p.m.) in the summer session. Ten-week courses are scheduled in the fall, winter and spring and specific subjects may be provided through a one, two or three-quarter course. Study groups in important subject areas are offered to various groups. The Center will occasionally provide or cosponsor weekend or longer conferences. It also provides 3-month full-time special courses designed to retrain hospital personnel moving to community mental health responsibilities. (The decision to provide continuing education primarily through the ½-day sessions, weekly, over a long period of time, has been supported by organizations and professionals who view their participation in Center courses as strongly linked to organizational and job responsibilities, and, therefore, appropriately occurring during the work week.)

Students

The Center, from its beginning, has identified students as participants, to underscore their responsibilities as learners. The selection of trainees is based on their organizational responsibilities to maximize delivery system effects. For 1971–72, enrollment figures by discipline were: psychiatry—87; clinical psychology—48; social work—229; nursing—40; other doctorates—13; other—74; for a total of 491.

Program Evaluation

No support is currently specified from core budget for program evaluation. The following efforts are used to critically evaluate programs: (1) assessment of educational need and content through periodic surveys of individuals by profession, role and organization, advisory committees representing constituencies, trainee evaluation questionnaires, requests for training from nontrainees, legislative bills affecting delivery system priorities, administrative plans affecting delivery system priorities; (2) assessment of ongoing content and process of course through structured verbal reports of trainees, and advisory committee reports; and (3) assessment of the effectiveness of training through anecdotal descriptions of service delivery program changes, trainee questionnaires at the end of a course, and structured, verbal reports of trainees.

The design for survey of need and assessment of specific educational activities has potential for replication and has been shared both formally, through publication, and informally, through consultation with other continuing education programs.

Community, institutional, and organizational impacts have been reported by course participants in the following areas: changes in agency policy, interagency policy, inservice training; new legislation and research proposals; organizational role clarification, increased citizen involvement; broadened use of community resources; improved continuity of care; development of preventive programs; and coordination of resources.

The major change which has occurred has been in the reformulation of the Center's goals to be responsive to the Southern California constituencies' requests for: (1) broadening the definition of mental health professional to include persons with program responsibility in the subject area of a course; (2) development of new and expanded educational content; (3) location of interorganizational, interdisciplinary education in more accessible locations. The decision to modify the initial Center program objectives when it started in 1966 was reached through a process of deliberation with staff, participants, advisory committees and service organizations.

The major strengths of the Center's program are seen in its essential linkages to the delivery system at all levels; in its flexibility and responsiveness to new and changing educational needs on the part of the mental health and health organizations; and in the educational design which links a variety of knowledges and perspectives from guest experts to an interdisciplinary, interorganizational, cross-section of participants. The weaknesses relate to the difficulties in making the program accessible to outlying locations and the lack of current resources to link research to the educational program.

Psychiatry–Mental Retardation

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MH10473 1967–1974

Objectives

The general objective of this training program is to acquaint psychiatrists, other physicians, and mental health personnel with the syndrome of mental retardation—its causes, means of prevention, methods of treatment, and case management.

The program is designed to provide an intensive, brief training sequence in mental retardation for the following strategic personnel: Faculty members who have had little exposure to the field of mental retardation but who have acquired teaching or administrative responsibility for mental retardation; psychiatrists, child psychiatrists, pediatricians, and pediatric neurologists, or residents being trained in one of these disciplines; and new key personnel in mental retardation or mental health programs. The purpose of the program is to expose these individuals to highly organized material that indicates the relevance of their existing knowledge and adds necessary information. For new personnel in the field the course provides an orientation to the subject and serves as a springboard for further learning and specialization.

Methods and Content

The main methods are lectures, seminars, demonstrations, case presentations, discussions, field trips, and consultations. The specific content areas and the approximate number of hours devoted to each are: The Characteristics of the Mentally Retarded—8 hours; Biological, Genetic, Neurological, and Exogenous Factors in Mental Retardation—12 hours; Developmental, Socio-Behavioral, Psychological, and Anthropological Aspects of Mental Retardation—10 hours; The Disciplines That Work in the Field of Mental Retardation and Psychological Reactions of Caretakers and Parents—10 hours; Principals of Planning, and a Review of Current Service Systems—Educational, Community Programs, and State Hospitals—18 hours; Examination, Diagnosis, Classification, Case Management, and Office Practice—12 hours; Special Issues, Trends, and Dilemmas in the Field of Mental Retardation, Including Legal Issues—10 hours; for a total of 80 hours.

Three courses are given a year. Each course lasts 2 weeks. The participant spends 40 hours a week in the course.

Students

In the year 1971–72, the following disciplines were represented: 49 physicians, including 14 child psychiatrists, 19 psychiatrists, 4 pediatric neurologists, 6 pediatricians, and 6 others; and 40 nonphysicians, including 6 nurses, 10 social workers, 7 educators, 12 psychologists, and 5 others.

Participants come from States west of the Mississippi River. Most of the physicians represent the specialties of psychiatry, child psychiatry, pediatrics or pediatric neurology. About 30 percent are in training at the time they take the course. The nonphysicians are typically fully trained professionals in their own field.

It is estimated that the population of potential trainees is about twice the number served. Nearly 50 percent of all applicants must be screened out due to the limitations on the number of students that can be accepted.

Program Evaluation

Participants provide a written evaluation of each lecture or topic. They also provide a written evaluation of the overall course. This information is tabulated and passed on to the faculty. It is used in planning subsequent courses and, in part, to determine which faculty members are invited to participate.

The potential for replicating this program at local, regional, or national levels is good. A similar program is given at Waverly, Massachusetts. In light of the demand, these programs should be developed in each region of the country.

The project is having a significant impact on the training of psychiatrists at various schools. Each course accepts at least one psychiatric resident from the Menninger Program, the University of Minnesota, University of Oregon, and the Malcolm Bliss Mental Health Center. A number of the graduates hold responsible academic, administrative, or service positions.

The major strength of this program is the quality of learning that emanates from this intensive educational experience. Each course has a quasi live-in arrangement. Participants learn a great deal from each other outside of the formal classroom situation. The greatest problem has been obtaining a satisfactory faculty member to handle the sessions on the role of the psychologist and techniques of psychological assessment.

This is an innovative approach to continuing education in mental health because it has the potential of providing, at a relatively low investment of time and money, immediate help in alleviating the shortage of mental health manpower who can work with the problem of the retarded. Another innovative element is the synergistic educational effect resulting from the 2 weeks, with no interruptions and continuing into the informal activities of the participants.

Continuing Education in Mental Health

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MH12321 1970–1973

Objectives

The general purpose of the continuing education program of the Staff Development Department at Fort Logan Mental Health Center (FLMHC) is to develop its outreach effort to rural areas of Colorado. Additional goals have concerned helping to develop systems related to mental health services by generating training programs both at the content and process levels and developing a self-renewing system for continuing education services. A related set of long-range goals involves broadening the roles of professionals and lay persons in the establishment, maintenance and integration of training, indirect service and direct service systems based on unmet community mental health needs.

Methods and Content

As its major training method the continuing education project has used short-term, usually residential workshops emphasizing experiential designs, simulation exercises, and demonstrations. Content areas have included (with corresponding course hours in parentheses): training of mental health educators (68); team building (45); therapy modalities (28); conflict management (18); consultation (15); community organization (15); and program planning (14). Workshops have ranged in length from 2 to 6 days of 6 to 10 contact hours per day, with 3 days the most common length.

Students

Students have represented the following disciplines and groups: psychology, psychiatry and social work (342); lay persons (70); education (62); nursing (19); school psychology (16); and administration (5) for a total of 542. Most of these participants have been from rural areas of the Rocky Mountain region.

Program Evaluation

Program evaluation has focused upon the outcomes of training activities in terms of trainees' reactions, learning, and posttraining behavior changes, and the impact of the latter on their colleagues, organizations, and clients. These outcomes have been assessed through postmeeting reaction questionnaires completed by trainees; through followup questionnaires completed by trainees, their supervisors, and peers, and the consumers of trainees' programs; and through continuing informal contacts between these persons and the continuing education staff.

Several key training programs such as workshops on team building and on the training of mental health educators have been replicated at the local and regional levels in the last 2 years. The descriptive information in the aforementioned reports should facilitate further replication by their agencies.

One impact of this project to date, at the intra-institutional level, has been increased participation by the FLMHC Staff Development Department in providing training to other agencies. Community impact has occurred through the continuing education project's facilitating the formation of a "learning community" in a rural town, composed of lay persons concerned with issues related to mental health. The project plans to involve cotrainers from such communities in its workshops in order to expand further the system for delivering training in these areas. Finally, regional inter-institutional impact is shown by the development of a commitment by two comprehensive centers and two clinics in northeastern Colorado to affiliate for joint inservice training of their staffs.

The major strength of this project has been its ability to coordinate multiple resources from mental health and allied institutions and from the community at large for the purpose of developing a self-renewing system for continuing education services. The program also has supported other groups (e.g., the Metro-Denver Consortium for Continuing Education in Mental Health) in developing a regional system for collaborative planning on mental health issues. A major weakness of the project is its limited staff and funds for meeting out-of-State requests for training.

The innovative aspect of this program is its application of systematic conceptual frameworks to the process of building training systems related to mental health. These frameworks are preventive mental health and "applied behavioral science," and specify, respectively, the need for and position of integrated training systems within broader mental health and allied service systems, and the kinds and sequencing of processes for developing such training systems where their necessary elements initially range from unintegrated to nonexistent.

Continuing Education for Mental Health Educators

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MH12293 1971–1974

Objectives

The general objective of this continuing education program is to provide mental health educators with an opportunity to increase their skills in planning and conducting mental health education programs. The specific objective is to alter local mental health education programs so that they become a more positive force in the community.

Methods and Content

The program consists of from four to six separate 5-day seminar-workshops conducted each year within the 3-year project period in different sections of the United States. Students are limited to 20 for each meeting.

Faculty includes members of the Mental Health Materials Center professional staff augmented by guest lecturers who have achieved distinction in the communications art and mental health education. The workshops consist of demonstrations of educational techniques and clarification of certain tools of communication available to the mental health educator. Presentations are followed by group discussion. Advance readings pertinent to the subjects are sent to the participants and resource material distributed at the seminar.

Content areas vary according to the specific needs and interests of the participants. The 2-day pilot seminar and the first 2-week seminars included such topics as "Principles in the Effective Use of Materials," "New Information Programs at NIMH." "Developing Effective Mental Health Approaches Through the School Curriculum," "Principles in the Effective Use of Materials," and "Developing a Mass Media Education Program." During the second program year workshops are scheduled on "Effective Use of Telecommunications in Support of Mental Health Education," "News and Views of Federal Programs in Mental Health and Family Life Education," and "Developing Effective Approaches to Mental Health Education in Schools." Two additional workshops are to be scheduled exclusively for mental health paraprofessionals engaged in a variety of community settings. Each workshop usually runs for 5 days, beginning on Sunday night to Friday afternoon. A total of 30 hours is spent in planned sessions, plus many hours of informal exchange and discussion between participants and faculty.

Students

All the potential students are employed in positions with primary responsibilities for mental health education. They may function as planners of State mental health education programs or they may conduct mental health education programs at the community level. They may be expected to develop educational materials fulfilling their objectives. They come from a wide diversity of backgrounds and original disciplines. Out of 29 participants in the first 2-week seminars, 6 were from education, 4 from psychology, 4 from journalism, 4 from nursing, 3 from social work, 3 from the ministry, 1 from psychiatry and 4 from no specific field.

For these students, there are, at present, no opportunities to acquire skills in mental health education save through trial and error on the job. It would be impractical for most of them to take time off to pursue formal academic courses. This project is designed as continuing education for persons now employed.

Program Evaluation

Program evaluation is done in a variety of ways. A week after each seminar, a questionnaire is mailed to the participants and is returned anonymously. Suggestions and comments made are analyzed and used as the basis for changes in subsequent seminars. In addition to favorable comments about specific aspects of the programs, all from the first two seminars who replied (80% of participants) felt the program was valuable enough that they would also like to attend another seminar on a different aspect of mental health education.

As the project moves into its later years, followups will be made at periodic intervals with students from early seminars and administrators of their agencies to assess the impact on State and local programs of what they learned in the seminar.

Many professional organizations, such as the National Association for Community Mental Health Centers, the National Association for Mental Health Information Officers, and State and local mental health programs, have been exploring with the Mental Health Materials Center Continuing Education Program the possibility of tailoring mental health education workshops for members of their groups or staffs. This interest has developed out of the continuing education seminars already held. This is one indication of the impact that the seminars have had. It is also a sign that few opportunities, if any, are available for the continuing education of persons moving into, or cooperating in the field of mental health education.

The training capability of the Mental Health Materials Center has been greatly expanded since July 1972. Our training program has been extended to include conducting 110-week-long training laboratories designed to train persons with drug abuse education responsibilities in acquiring the necessary skills to use "The Social Seminar" for inservice training for educators, and those engaged in a variety of community-based drug abuse education activities. This assignment is being carried out under contract with the National Institute of Mental Health.

Continuing Education for Personnel Working With Youth

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MH12535 1971–1974

Objectives

The objectives of this project are to assess the need for and develop inservice and continuing education for youth-serving personnel, both professional and lay youth workers, in the Minneapolis Model Cities area. In working toward these goals, the program seeks to provide continuing consultation to a variety of youth-serving organizations, through active involvement with boards, administrators, and personnel, placing emphasis on staff development. Training sessions are designed to develop community "caretakers" among youth workers, by providing intensive instruction in areas such as group dynamics, small group process, leadership, conflict resolution, community mental health, minority group cultures, communications skills, program planning, personality and identity formation, crisis intervention, data gathering, and self-awareness. Another program goal is the development of additional methods of youth work in practical, usable forms through publications and speaking engagements, and by providing access to local and university resource persons.

Methods and Content

The training process reflects the belief that most youth-serving organizations can become self-renewing, and that considerable expertise and creativity exist in the staffs of such organizations. The initial approach of the program requires considerable consultation regarding staff interaction, sharing, objectives-setting and consensus. Success with this approach enhances the ultimate commitment of the organization to seek appropriate training goals.

Before developing a training program the consultant and the organization decide jointly whether the inability of the organization to achieve its youth-serving goals reflects: (1) a lack of skill which requires training, (2) a lack of performance which requires little training, but might require a change in organizational conditions, or (3) a combination of both lack of skills and lack of performance.

Because organizational commitment for training is strengthened through the active involvement of the organization, the client is required to work with the consultant in developing a relevant training plan. The resultant training program is conducted by the consultant, selected personnel from the University of Minnesota, and relevant skilled persons in the local community. Predeveloped training "packages" are seldom offered, because this program is collaboratively involved with youth, youth-serving organizations, community organizations, and university faculties in continually developing, designing, and operationalizing training programs. While the training methods draw heavily upon organizational development approaches, methods used in specific training programs primarily adopt the following sequence: lecture/discussion, group experience (role-playing, simulation, etc.), on-the-job application (or on-the-job recognition of the concepts), and a synthesizing discussion. When appropriate, videotape is used to provide immediate feedback and/or evaluation in skills training.

Specific content areas of training vary in length, depth, and intensity according to the assessed inservice needs of the organization. The developed content could maximally include the following: Youth Identity and Personality Development, 20 hours; Adolescent Development (Moral and Cognitive), 15 hours; Family Life Styles, 10 hours; Group Dynamics, 10 hours; Communications Skills (including interviewing skills), 8 hours; Conflict Resolution/Crisis Intervention, 8 hours; Community Mental Health (prevention and intervention), 10 hours; Program Development and Planning, 10 hours; Human and Race Relations (inter-group), 15 hours; Rudimentary Survey and Evaluation Methods (including participant-observation skills), 4 hours; and Self-Awareness, 15 hours.

Students

Clientele of this project represent a broad range of disciplines, professions, and vocations. The educational and academic backgrounds in any training course generally cover the spectrum from elementary schools through the master's degree. Categories of students and the numbers served include 100 youth workers from various model cities programs, 10 administrators of model cities organizations, 130 public school teachers and administrators, 90 policemen (patrolmen and supervisors), 50 correctional counselors or counselor trainees (many are ex-inmates), 50 Minnesota State Civil Service employees, 20 special education teachers and psychologists and social workers, 50 YMCA/YWCA workers, and 130 university graduate and undergraduate students enrolled in courses taught.

Program Evaluation

Each training program is developed with a statement of agreed-upon specific objectives which are evaluated using a Likert scale design. Organizations are encouraged to assess whether a training program was relevant in helping to diminish the problems which originally occasioned the need for training.

Many of the programs are replicable for other organizations and agencies. Because each program is especially planned and designed jointly with a particular client population, replication of any component might be best attained if the same planning process were repeated.

The major strength of this project lies in the broad and active involvement of its clients. While this process is often intense, the resultant training programs and courses have been considered highly satisfactory, with additional requests made for more training.

The growing list of groups participating in this project attests to the acceptance of this approach. This project has been continually and increasingly involved with over 50 organizations.

Mental Health Association Staff Development Operation

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MH09544 1967–1973

Objectives

Under the NIMH Grant the National Association for Mental Health has planned a nationwide staff development program for its 300 full-time executives in Chapters (local) and Divisions (State) throughout the country. The overall objectives are to achieve continuing, self-directed education by the professional staff and to increase their ability for managing with volunteer leaders the local and State associations. (Plan has been designed and tested but not implemented.)

Each participant sets objectives, based on his/her learning needs as they relate to the needs of that person's organizational unit. A learning plan for an 8–10 month period is designed to meet the objectives—after its completion the process is repeated. Learning objectives are stated as behavioral outcomes and are measurable.

The implementation of the nationwide program calls for bringing into the program 20 percent of the population the first year, 10 percent the second, and 10 percent the third. Limiting the number is necessary in order to ensure that guidance and resources needed by participants to achieve their objectives and plans are provided.

Methods and Content

Each participant, with guidance, identifies the area in which his/her organization is weakest. The areas covered by the program include:

(1) Administration of an office, personnel, and finances of an MHA;
(2) Management of Financial Development;
(3) Management of Human Resources Development;
(4) Management of Program Development.

Next, the participant assesses his/her organization against performance standards for that area to identify standards which should be met. The standards in all areas except administration are stated as outcomes resulting from the basic management functions of plan, organize, lead, and control. Standards also reflect organizational goals and values.

After grouping and setting priorities among standards to be met, the participant determines whether achievement is dependent on his own ability or on certain conditions which must be changed. Those standards which depend on his learning ability are translated into learning objectives. He then determines the knowledge, insights, and skills he needs to develop. A learning plan is developed with appropriate methods/resources, schedule, budget, and evaluation guide. Standards dependent on conditions which must be changed are translated into change goals. Change strategies are selected, and a plan is developed.

In a 3-day seminar the participants learn the self-directed process of learning and develop their first plans. Afterwards the plans are filed with a Training Director who follows up periodically over the next 8–10 months to counsel participants and help them locate resources and assistance. The individual carries out his plan in the setting where he lives and works through home-study, local courses, consultation, and training from peers or other resources. Variety in methodology is stressed. At the end of the first learning period, the participant evaluates progress toward the objectives he set for himself, initiates the diagnostic process again, and creates his next plan.

Students

The 300 full-time executives represent a variety of previous backgrounds. The majority are executive directors, and the remainder fill specialty positions such as fund raising, program, and publicity.

The dominant homogeneous factor is that they work for the same organization which has the same overall goals. Heterogeneity is mainly in the performance of each organizational unit and the experience and managerial ability of each executive.

Program Evaluation

For 3 years an evaluative researcher will obtain and analyze data from experimental and control groups to determine actual changes in staff performance which contribute to the achievement of performance standards and result from the Staff Development Program. The experimental group will consist of Staff Development Program participants; the control group, of staff who have not entered the program. Additionally, feedback will be obtained from participants to update and revise performance standards, improve materials, and advance the development of the overall program. Decisions on program changes will be made by an Advisory Council. This Council will be the planning mechanism for the continuing development and renewal of the program. It will represent the organizational leadership, training population, and the competencies needed. (Such a mechanism guided the efforts of the Project Director in designing the overall program.)

The principles of staff development utilized by the program can be applied to other settings. The content is relevant ot the MHA only, although it could be modified for use by other volunteer agencies.

Since the plan has not been implemented, no major impact has been made on the organization. However, a pilot seminar which tested the applicability of the principles, and open communication throughout the planning phase have resulted in enthusiasm among staff and volunteer leaders for implementing the plan.

The pilot seminar resulted in major changes in the design of future seminars. Slower pace and more skill practice are the major improvements to be made in future seminars.

The greatest strength of the program is its emphasis on continuing self-directed learning and the congruence of organizational and individual needs. The writing of performance standards is felt to be a substantial contribution in that they codify the expectations for local and State units and the role of the Executive staff. The major weakness is expected to be in the delivery of assistance to participants for achieving their plans. The training population is spread throughout the country. In addition, funds for staff development materials and activities are limited.

Continuing Education for Mental Health Manpower

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MH12955 1972–1974

Objectives

The general objectives of the Nebraska Psychiatric Institute's program, Continuing Education for Mental Health Manpower, are to (1) provide continuing education programs for the manpower who are significant for the delivery of mental health services in Nebraska, and (2) develop a method for providing these programs that will consider existing educational systems, the needs of consumers, accessibility and frequency of programs, the philosophy of adult and continuing education, and program effectiveness and efficiency.

These objectives are met in specific ways, with the needs of trainees identified by surveys of representative individuals and agencies in the field of mental health. Program content is determined by these needs and is presented in workshops and conferences. During the planning phase of the program, a questionnaire to assess areas of interest, suggested topics, and potential speakers was sent to about 325 individuals and agencies representing the following groups: (1) professional organizations, practitioners, and educators in medicine, social work, nursing, psychology, law, the ministry, education and occupational therapy; (2) the Government, including Medical Services of the Department of Public Institutions, Department of Health, and Department of Welfare; (3) continuing education departments; (4) extension divisions; (5) mental health associations; (6) potential consumers; and (7) patients. Current program emphasis, as determined by the results of the survey, is on the needs of the professional and paraprofessional mental health worker, with workshops and conferences planned to enhance skills in preventive psychiatry, early case finding, diagnosis and evaluation, treatment methods, and rehabilitation.

The decisionmaking process in planning and implementing the program involves both the potential trainees, in making their needs known, and the program's coordinator and Advisory Committee (which includes faculty and staff, consumer representatives, and patients), who study these needs, set program priorities, and plan the programs.

Methods and Content

The methods of training vary according to the topic, faculty, and students involved in each program, but workshops and conferences, usually 1 or 2 days in length, consisting of lectures, live and videotape demonstrations, panel discussions, and small-group discussions are the usual methods of presenting the programs. Specific content areas are determined by the response to the original survey, the requests of trainees attending the workshops, and the advice of the program's Advisory Committee and the Nebraska Psychiatric Institute's Faculty Committee. Workshops scheduled for the first year include, "An Introduction to Transactional Analysis" (2 days), "Advanced Theory in Transactional Analysis with Emphasis on Banal Scripting and Man-Woman Relationships" (2 days), "The Nurse in the Mental Health Field: In the Community" (1 day), "Everybody Evaluates Programs—But How?" (1 day), "Psychopharmacology with Special Emphasis on Side Effects and New Research" (2 days), "Changing Styles in Psychiatric Syndromes with Particular Emphasis on Personality Disorders and Their Management on an Inpatient Service" (1 day), "The Nurse in the Mental Health Field: In the Hospital" (2 days), "The Nurse in the Mental Health Field: In the General Hospital" (1 day), and "The Nurse in the Mental Health Field: In Consultation" (2 days). Topics under consideration for other programs include individual psychotherapy, depression, child neurology, and current issues in preventive and community psychiatry. Programs are presented by authorities from all over the United States.

Students

Students in this program are employed in the various mental health disciplines, and include social workers, psychologists, vocational rehabilitation counselors, occupational therapists, nurses, teachers, case aides, administrators, clergy, law enforcement personnel, physicians, and welfare workers. All programs are presented to a multidisciplinary group at the Nebraska Psychiatric Institute and are broadcast via two-way closed circuit TV to the three Veterans Administration Hospitals in Nebraska. An average of 203 students attend each workshop.

Program Evaluation

Program evaluation has several components: (1) an evaluation questionnaire filled out by each student at the close of each workshop concerning program content, knowledge gained, relevancy to the student's work, and anticipated application to patient care; (2) evaluation meetings with participants and the Faculty and Advisory Committees, and (3) consultation with experts in evaluation and in adult and continuing education. This program has great potential for replication in other areas. It could be carried out wherever adequately trained staff and teaching facilities are available. The community impact of the project is difficult to determine now, since this is a new program, but the evaluation questionnaires on the workshops that have been given indicate that the programs are of great value and that students will apply what they have learned to their professional work. Improved patient and client care will result. This program is an innovative approach to continuing education in mental health because it is interdisciplinary and encourages communication among all the mental health disciplines.

Community Based Training for Mental Health

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MH12674 1971–1974

Objectives

The continuing education program of the Tufts Department of Psychiatry and Tufts Mental Health Center, entitled Community-Based Training for Mental Health, is designed to: (1) increase the therapeutic skills of professional and nonprofessional staff in the delivery of mental health services to the communities of South Boston, North Dorchester, Columbia Point and Chinatown; (2) improve the efficiency of delivery of mental health services to these communities; (3) change professional attitudes and "set" toward the development of a primary prevention and outreach viewpoint in the community, in place of a more conventional, service-on-request model; (4) increase the understanding of and attitudes toward mental health issues within the various communities through staff training and public education methods; and (5) provide flexible program evaluation allowing for changes and addition of new courses and training methods to meet the changing needs of staff in response to consumer demands for service.

Specific objectives include the following:

1. To increase effectiveness and scope of child psychiatric services in the community. This priority was determined by a felt-need survey several years ago in the catchment area. Training has included courses on child development, families, and group methods related to children. Target groups have included welfare workers, youth activity workers, and paraprofessionals involved in the treatment of children.

2. To increase utilization of group methods in the treatment of adults and children in the community. This goal reflected the relative paucity of group treatment within the agencies of the catchment area. Courses in group techniques and therapy have been offered during each fall semester of the present program.

3. To increase time spent in mental health education and attitude change activities within the community. Courses are being offered on topics of general interest—law and poverty in the community, drug abuse, etc.—in an attempt to reach citizens and influence attitudes.

4. To increase skills in crisis management of patients in the community. Training has attempted to increase the skills and techniques available to crisis workers, and to

encourage more active intervention when appropriate.

5. To improve understanding of theory and utilization of techniques in mental health consultation. This reflects an attempt to broaden the involvement and skills of agency staff in consulting to institutions and agencies, and thus to increase the effectiveness and influence of staff. This goal involves training in and emphasis on mental health consultation for staff.

Methods and Content

Training methods in the Tufts Continuing Education Program included courses and seminars, workshops, agency consultations, and training groups. An attempt is made to standardize teaching principles for all courses, consistent with principles of adult education. Staff training for adult teaching is being implemented.

Content areas are varied and have included courses in: Child Development and Problems of Adjustment; Crisis Intervention and Brief Psychotherapy; Group Theory and Psychotherapy; Family Theory and Therapy; Drug Abuse; Law and Poverty in the Community; Principles of Social Work; Problem Solving Techniques for Neighborhood Workers; Clinical Psychopharmacology; Staff Relations and Change; The Community and Delivery of Health Services; Care and Aftercare of Chronic Mental Patients; Mental Health Consultation and Education. Most courses are offered on a once-a-week basis for 8 to 12 sessions.

A 2-day workshop was offered entitled Families in Trouble, attended by community workers in welfare and other social agencies. This workshop involved multi-media presentations, lectures, and emphasized small discussion groups. Workshops in the coming year are being planned on Alcoholism, Writing Techniques for Professional Journals, and Treatment of Homosexuals.

In addition, consultation to specific agencies has been offered by the Continuing Education Program, both with regard to case management and particularly emphasizing staff relations.

Students

This program is multidisciplinary, with the trainee population variable in professional training and years of experience. The largest proportion of trainees are nonprofessionals followed closely by social workers. Other groups (in smaller proportion) include nurses (both psychiatric and otherwise), psychiatrists, psychologists, teachers, and recreation workers. The number of students is steadily increasing, with the following figures of active course participants for the first three semesters of the program: fall, 1971—50; spring, 1972—76; fall, 1972—111. In the one workshop offered so far, there were 60 participants.

Program Evaluation

Evaluation questionnaires on attitudes and course expectations for each of the courses offered were compared before and after course completion. Demographic and experiential data for all trainees are also obtained, including the number of target population treated, both before and after a given course is completed. Evaluation includes staff and trainees primarily. Similar data has been collected on the fall workshop.

The unique quality of this program is its part-time nature; the multidisciplinary background of the trainees, and the fact that the program is based within the activities of a community mental health center. Given these factors and adequate consultation with catchment area staff for a given mental health center, the program is replicable.

The project has had a strong impact on the activities of the community mental health center by causing a re-evaluation of its training priority, and the specific priorities for training within the community mental health center. The program has also served to increase communication between staff in the component agencies of the Tufts Mental Health Center and the central mental health staff itself, particularly over issues of planning for various training endeavors.

The major strengths of this program are implied in the various objectives mentioned above, i.e., that it is multidisciplinary, part-time, rooted in a community mental health center, with much effort at student participation in establishing their own training priorities. Some of the drawbacks of this program include the difficulty of engaging some staff in participating in the planning process; the reticence of psychiatrists to participate in a multidisciplinary program; the difficulty in attaining uniformly high quality seminars; and finally, tension between the central administration of the community mental health center and the autonomous structure of the participating agencies. The program is innovative, in that it is catchment area-based, and emanates from a community mental health center. Also, since it is part-time, it offers inservice training to agency staff.

Continuing Education–Psychiatry

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MH11323 1968–1973

Objectives

The program of Continuing Education in Mental Health at the University of New Mexico was envisioned as a diversified, flexible and live program using a variety of techniques, content and materials to meet the central objective: to improve mental health services to all citizens of the State.

Specific objectives vary with course content and trainees. They have ranged from instructing "expert witnesses" (psychiatrists and others) in courtroom skills, to assisting family members to make decisions together; from instructing professional and semiprofessional "care-givers" in methods to combat crises—from drug abuse to suicide threats—to discussing with educators, employers and law enforcement personnel the handicaps of various groups, such as ethnic minorities, the physically handicapped and ex-convicts, and the rehabilitative measures needed to make them functioning members of society.

Priorities are established with one basic criterion: to bring to each content area the expertise and the insights of a broad cross-section of resource people to assist trainees to develop skills in areas they themselves have identified. Assessing training needs of the caregiving population (through personal discussions and written queries) is an ongoing process. Pilot educational programs are devised using a variety of techniques and materials to meet these needs. Subsequent evaluation of both methods and results and a followup 6 months later on long-term effects of the program on the individual's performance, provide a gauge to assess the program's effectiveness in meeting these needs.

Methods and Content

The program, operating in conjunction with the University of New Mexico School of Medicine, Department of Psychiatry, consists of workshops, seminars and institutes of varying lengths and content areas. These have ranged from 1-day to 1-week programs of 8-hour daily sessions with occasional meetings at night, as well as occasional 14–16 week, one a week workshops.

Content has varied, dictated by the needs of our target groups. These target groups, and examples of training programs for each category, are:

1. Mental health professionals—the "caregiver" specialists (psychiatrists, social workers, nurses, etc.)—who are provided with up-to-date and expanded knowledge in their fields via training programs, such as one entitled, "Psychiatrists on the Witness Stand." During this 1-day workshop held at the University of New Mexico School of Law, a moot courtroom trial involving judge, prosecutor, defense attorney, and defendant served to instruct psychiatrists and other "expert witnesses" on proper psychological observation and preparation of reports for courtroom presentation. Another program, In and About Groups, a 2-day institute held on the University of New Mexico campus with a followup session at Las Cruces, involved participation in group interaction. A large group presentation was followed by workshops covering such areas as: how to work with adolescents and youth, improving organizational climates, encounter groups, and role-playing and psychodrama.

2. Professionals whose occupations bring them into frequent contact with mental health problems. These "allied" professionals include general practitioners, ministers, educators, school counselors, etc. Examples of programs include two institutes designed to meet the needs of this group. In a 2-day institute, Working with Family Units, a practicing psychiatrist brought in a five-member family whom he had in therapy, and gave them tasks involving family decisions. Each family member went with a small

group of trainees to be interviewed, after which one of the trainees had to role-play the family member before him. The purpose was to point out patterns of family interaction. A 3-day institute, Serving a Multi-Ethnic Population, held at the Ghost Ranch in Northern New Mexico, covered such topics as the emotional experience of "what it means to be a minority"; the specific problems of minorities: psychological impact, education of the culturally different, etc.; how minorities can be better served; and the sociology of language. All sessions were interspersed with small group discussions.

3. "Nonprofessionals" whose interest in people and their problems make them worthy contributors to mental health programs in such capacities as OEO Outreach Workers, mental health workers, and student and other volunteers. Programs designed to meet the needs of this group include: a 2 day institute on Grouping and Coping, in which the psychological, cultural and social aspects of illness were illustrated; and the Laguna Community Workshop, held for 2 days at the Laguna Indian Pueblo, 40 miles west of Albuquerque, which addressed itself to training Laguna people to work with problems of emotional crisis.

Students

Students range from highly trained professionals to rural, unskilled workers. An example of the latter was a "Community Awareness" institute held in Vallecitos, a farming community in northern New Mexico. The program, which "took the caregivers to the people," was attended by virtually the entire village population who were extremely articulate at identifying their needs "from the grassroot level."

Program Evaluation

The short, post-institute evaluation by trainees and 6-month followup have been described under "Objectives." The most frequent and, perhaps, significant evaluation by trainees is that they have discovered new ideas which could be attributed to the educational experience of the institute. An almost unanimous response is: "Yes, we want more continuing education programs in mental health." The project, in turn, asks "In what areas?" and proceeds to develop institutes around these.

Plans are being developed to turn over program evaluation to an independent agency on a contract basis.

The potential for replication on a regional and national level appears to be excellent since resource people are drawn from the community and programs are developed to meet training needs identified by participants. Impact is individual and anecdotal: one participant went home and started a crisis program for drug abusers after attending a program on "Dope or No Dope: Alternatives, Tools and Techniques"; several have gone on to more institutes on the same subject; one student is in training as a group therapist; and another simply writes "The mood in our home is different. I like me and don't feel sorry for myself anymore. . . . I don't understand all this but I'm enjoying life; maybe this wasn't your goal but I'm grateful."

There have been no major changes from the original program intent which was to seek input from participants and resource people so that programs are naturally oriented toward what is needed.

The major strength of the program is two-fold: 1) Programs are directed from the community—the consumer group—with local people involved both as participants and as trainees, and 2) program activity is problem-oriented, not just subject-oriented, and directed toward application in the community for better mental health services.

When the program began 4 years ago, it was stipulated that four training institutes would be held annually. Last year, 26 such institutes and other training experiences took place throughout the State, yet the major criticism voiced by trainees was that "there are not enough to go around." This seems to be the program's major "weakness." Registration has had to be limited and people have been turned away on some occasions.

Our program has been innovative in working to reach such a broad cross-section in our trainee-audience, and in the techniques of the rural community type of presentation using local State resource people talking about local problems (e.g., Laguna Pueblo, Vallecitos).

As new approaches, techniques, and conceptualizations are developed which may be useful in better serving the mental health needs of the people of this State, the project stresses the need to be prepared to serve as an educational conduit to make these available in New Mexico.

Child Guidance Personnel

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MH12297 1970–1973

Objectives

The general objective of this program is to develop and maintain the relevance and effectiveness of the mental health practitioner in the schools, primarily in terms of the interactions of the school system with other forces for urban change; to work toward the establishment of an ongoing, self-generating program of continuing education within the Bureau of Child Guidance.

Specific objectives include the development of skills, knowledge and attitudes necessary to achieve the general objectives. Three general areas of interest are the school's responsibilities toward the child, the interaction between the community and the school system, and systems theory approaches to planning and evaluation.

Measurement of the program's effects will focus initially on direct applications of content, other changes in practice, development of plans for new service programs, and the nature of staff requests for training opportunities. Other criteria may be added as evaluation proceeds.

Methods and Content

Methods have included seminars, workshops, lectures and observations of programs. Audiovisual presentations have also been used.

Specific content areas include: (1) school-related-education problems (learning disabilities, reading remediation, classroom management, reality therapy, open-corridor approach, special education) and new intervention techniques (drug abuse prevention, sensitivity training, family therapy, behavior modification); (2) community-related-ethnic issues (life styles, politics and economics) and community issues (community organization and consultation, group conflict resolution, mental health services for the hard-to-reach); and (3) systems approaches-evaluation (service and performance) and planning (management by objectives, levels of service in budgeting).

The time sequence and total course hours have been as follows: (1) weekly presentations—1½-hour sessions, late afternoon, 1 to 15 sessions; (2) evening courses—3-hour sessions, once weekly, 10 to 15 sessions; (3) weekends—6-hour daily sessions; 1 to 4 days; (4) summer vacation—two 3-hour sessions weekly for 5 weeks. The total course hours for the first year was 249, for the second year 523, and for the third year (now in progress) 226.

Students

The number of trainees who have participated in the program is about the same as the number of the staff, for those programs presented at regular Center meetings. The distribution by discipline follows: psychiatrists—77, psychologists—303, and social workers—352, for a total of 732. A number of professional trainees also have participated.

All of the psychiatrists have the required education and training; many are board certified. Psychologists and social workers range from masters level to doctoral; some are currently engaged in further graduate studies; many also have engaged in other educational and training activities.

Program Evaluation

Program evaluation has been carried out, formally, in questionnaire surveys of staff interests, program participation and reactions. Evaluative questionnaires were distributed to consultants and participants after completion of a program. Questions also were posed, informally, in conversation with participants. Future plans call for a study of various applications of program content and assessments of the persisting effects of the program, in terms of individual knowledge and attitudes, and significant changes in activities and programs.

The potential for replication of the program is great in terms of the basic concept of continuing education as a necessary component in public service programs undergoing continuous and significant changes that are too rapid and complex to be met by existing training facilities. Beyond that, the success of attempted replications will depend on the availability of resources, of which the most important is a good supply of competent consultants.

Formal efforts are underway to assess the impact of the program on the community and the Bureau. Informal information indicates that significant effects have already been produced, including the application of reality therapy methods in a number of schools in two districts and changes in the practices of some staff members in dealing with individual cases.

Program changes, in response to staff requests, have been minor in character. These include an increase in the number of decentralized courses and changes in content emphasis. The program remains, however, well within the original guidelines.

The strengths of the program include the flexibility of planning for highly specific as well as broader subjects, the availability of highly-qualified consultants, the voluntary nature of staff participation and the crossing of interdisciplinary boundaries, in terms both of content areas and the disciplines represented by participants. Most important is the program's contribution toward increasing the effectiveness and relevance of a major mental health service, with far-reaching influence on the education and mental health of a large population of children. The only significant weakness in the program is the limited time available, within the current framework, for careful evaluation of the program's nature and effectiveness.

The innovative character of the program is apparent in a number of ways, most striking of which is the positive effect on staff morale. Many participants have reported increased awareness and initiative in their field work. The most significant part of their response is that the program provides them with the kinds of theoretical and practical knowledge and skills that they need and that cannot be readily obtained elsewhere. A number have expressed the conviction that this is a very good thing for the Bureau and that they are looking forward to its continuation.

Continuing Education–Mental Health

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MH12165 1972–1975

Background

As the mental health programs in North Carolina have grown and changed, the need for continuing education for the professional and nonprofessional staffs of these programs has become more pronounced. It also has become clearer that professionals working in allied agencies, such as health, welfare, schools, and law enforcement, and other professional individuals, such as physicians and clergymen, desire an upgrading of their professional skills as they relate to the mental health field.

In the light of these changing program needs, the shortages of staff and the necessity for maximum utilization of the skills of existing personnel, it becomes quite apparent that there is a need to provide for systematic continuing education programs, very broadly conceived. The Mental Health Training Institute is that resource. It is an interagency, interdisciplinary continuing education program for mental health and allied program personnel in North Carolina.

Established in 1969, the Mental Health Training Institute is a cooperative training program of the School of Allied Health and Social Professions, East Carolina University, and the North Carolina Department of Mental Health. The general purpose of the Institute is to develop and operate continuing education and inservice training programs for mental health and allied health professionals employed in North Carolina. Though originally created to meet the needs of Eastern North Carolina, the Institute's role has evolved to a statewide responsibility.

Activities of the Institute are supervised by an administrative board which includes representatives from East Carolina University, North Carolina Department of Mental Health and appropriate consumers representing minority groups.

Objectives

With the Board of Directors providing program direction for the Institute, the following objectives have been established: (1) to upgrade the skills of the mental health and allied personnel of North Carolina in the performance of their mental health prevention, treatment, and rehabilitation functions; (2) to continually assess the inservice training and continuing education needs of mental health centers, mental health clinics, and regional institutions for the mentally retarded; (3) to assess the relevant mental health continuing education needs of allied agencies (health, education, welfare, etc.), and the professions (clergy, physicians, lawyers); (4) to provide appropriate continuing education for specific target groups in mental health and allied fields; and (5) to provide for program evaluation of continuing education efforts as an integral part of the planned program of the Institute.

Methods and Content

With the sanction of its Board of Directors, the Institute has redirected the focus of the program to include the entire State of North Carolina. At the request of the Department of Mental Health, the Mental Health Training Institute has accepted the responsibility for consulting with "regional support teams" of the Department of Mental Health as well as assisting the Staff Development section of the Department in designing appropriate statewide training programs.

Designed for an interagency interdisciplinary audience, the training programs of the Institute are developed in response to training needs identified through surveys and interviews with program directors and their staff. Priorities are established through the Board of Directors; and consumers of the training efforts are involved in the actual development of the training experiences.

Developing training efforts in concert with the target group provides for relevant training experiences and assures the most effective implementation of the training programs. While providing content through didactic sessions is deemed important, emphasis is placed on the learning which takes place among participants in small group sessions.

Training Survey

Through a survey of training needs in 1970 and 1972, the Mental Health Training Institute has offered a series of training experiences for an interagency interdisciplinary audience representing all of the "helping professionals." The Institute's staff has been instrumental in assisting community and institutional programs in identifying needs, establishing priorities, and implementing effective training programs for mental health and allied health professionals.

The many offerings of the Institute include consultation skills, human relation training, management seminars, and secretarial training programs. Further issues and needs identified in the surveys include "mental health" needs of poor and minority groups, family therapy, drug abuse, education, and services to children and adolescents. The future focus of the Institute's program will be on improving the delivery of services to poor and minority groups, and upgrading skills of mental health and allied health professionals in child mental health.

Program Evaluation

Data has been collected on all training programs as participants have been asked to share their reactions to the offerings of the Institute. Trainees have been requested to evaluate whether programs have met the stated goals and objectives and are asked to provide suggestions regarding future training activities. Results, to date, indicate substantial acceptance of the various training programs as participants have found the offerings significant and valuable to their assigned jobs in their community.

A followup study of the Institute's initial year of operation is currently underway, financed in part by a grant from the North Carolina Department of Mental Health. This study will identify the learnings which have taken place in the various seminars and workshops and determine their effect on participants' job performance. Interviews have been completed by social work students at East Carolina University and data is being coded and analyzed by the North Carolina Department of Mental Health.

The Mental Health Training Institute is a unique attempt to develop a model of continuing education melding together the strengths and resources of both an educational and service organization. As the Institute continues to grow, it must make every effort to ensure that its training programs are tailored to the development and improvement of skills necessary to accomplish the stated goals and objectives of community mental health programs. Reviewing the findings of recent training needs surveys, the Board of Directors has sanctioned a three-fold program for the coming year to: (1) expand the number of training programs in response to the needs as expressed in the training survey; (2) increase consultation to mental health programs regarding the improvement of their own inservice training program; and (3) develop a "Materials Resource Center" for the accumulation, organization and dissemination of appropriate material to mental health programs.

Continuing Education–College Student Personnel

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MH11536 1969–1973

Objectives

The general objectives of the program are to improve the overall attitude toward mental health problems on small college campuses, and to stimulate interest and interaction between college student personnel administrators and local community mental health professionals.

Specific program goals are to provide specific recent research knowledge to student personnel staff members involved in mental health programs; acquaint health service nurses and physicians with availability of community mental health services; and assist paraprofessionals as well as university staff and civil service individuals in understanding mental health problems in college students.

Methods and Content

A four-day workshop with followup discussions is utilized as the educational technique to achieve the objectives. Also, resource materials are developed for use on local campuses. Specific content areas of each workshop are the result of questionnaires sent to prospective participants. In past years, these have included such topics as: legal questions, drug problems, group processes skills, crises intervention centers, special problems of women, counseling of minority students. The time sequence of a workshop is Tuesday noon to Friday afternoon (third week of July); consisting of approximately 24 hours of lecture, group process, and personal interaction activities.

Students

The trainees include approximately 40 student personnel professionals ranging from Dean of Students to counselors, admissions officers, and residence hall directors. Also involved are 30 college health service nurses, of whom three or four are physicians, and about 10 who are working in the drug problems category. Approximately 10 mental health professionals, ranging from social workers to psychiatrists and psychologists, are also included. Thus, there is a combined total of about 100 registered participants from approximately 50 colleges and universities.

Eighty percent of the participants have limited backgrounds in the area of mental health. Most participants come from the following backgrounds: nursing, internal medicine, counseling and guidance, general psychology, and personnel administration. The potential trainee population is estimated to be around 1000 to 1200 individuals in the Rocky Mountain Plains region.

Program Evaluation

All personnel attending the workshop, whether they be participants, resource individuals, or speakers, are provided with an opportunity to submit a written evaluation. The Student Personnel Department which carries on the program for the workshop presents evaluations.

The program could be replicated with some modification at local and regional levels, but because of the personalized activities, a national endeavor of this design would have limited value. Two mental health

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clinics have been established as a direct result of the past six workshops. Three other colleges have developed programs of interaction with community mental health agencies. During the course of the 6 years of the workshops, workshop personnel have been asked to sponsor programs at 10 national meetings of college personnel workers and college counseling directors workshops.

There have been no major changes in the training design other than attempts to continue the small group activity and maintain a relatively large number of resource personnel, preferably one resource person per seven participants.

The major strength of the workshop is the development of personal relationships between psychiatrists, M.D.'s, and personnel workers; and the development of the relationships between college personnel and staff members from community mental health centers. The program's strength is also demonstrated by the impetus it has given to stimulating concern about mental health environments in small colleges in the Rocky Mountain region.

The major weakness of the program is the limited time available to follow up on activities of workshop participants and resource personnel. In order to have more impact on the local communities, it would be necessary to have more intense followup activity.

Preventive Mental Health Through Skills of Community Caretakers

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MH12156 1970–1973

Objectives

The Caretaker Project is charged with training objectives. The major objective is to upgrade mental health skills of community caretakers defined as teachers, nurses, clergymen, social service workers, law enforcement personnel, and other community workers who are involved with people in stressful situations. A secondary objective is to determine what educational methods and interventions are most workable in this unique area, i.e., the Upper Peninsula of Michigan. At the inception of the project in the fall of 1970 the major target populations included 547 licensed practical nurses, 1,654 registered nurses, 120 social workers, 3,411 teachers, and 350 clergy.

An all-pervading objective of the project is to bring about a shift in understanding and dealing with people in times of trouble. Problems in living are understood as difficulties in relating and communicating. A behavioral goal is to have community caretakers respond to crisis periods as opportunities for growth or for a constructive redirection of one's efforts—as opposed to the start of maladaptive coping which may lead to the need for institutional care and its contingent high costs. The project objectives are not preventive in the traditional sense, but rather to teach processes which make effective use of existing personal energy and to mobilize community resources; in effect to learn self-help behaviors with a community orientation.

Methods and Content

Two educational-workshop models were proposed: the Interpersonal Process model (emphasis on personal experience) and the Developmental Process (emphasis on cognitive learning). In a curricular fashion the following content areas were originally specified: Communication Processes, Effective Help Giving, Conflict Management, Group Membership Roles, and Leadership Roles. For the interpersonal model, 3, 5, and 10-day workshop sessions were proposed; for the developmental model, 15-day sessions were proposed.

Participants

For the first 2 years of operation, comprehensive data is not available to adequately identify the number or type of trainees who participated in different phases of the project. Nurses, clergymen, teachers and college students participated in some phase of training. Volunteer community groups were and continue to be given high priority.

Program Evaluation

For the first 2 years of operation, attitudinal scales were devised for evaluative purposes. Data was collected from participant trainees; results are not now available. Since October 1972, identifying demographic data is being collected on all participants. Evaluative instruments of a self-report nature are being devised. These instruments will be administered to trainees to assess self-perceived change and their evaluation of community activities in which they are involved. Similarly, evaluative reports by the consumer will be solicited.

Although hard data on effectiveness may not be gained, the impression at this point is that there is good receptivity in the Upper Peninsula to the type of training now being provided. Given sufficient opportunity for participation, behavior change can occur which will result in a significant shift in the quality of interpersonal contacts—and some organizational change may follow. Insofar as behaviors can be learned, they are transmittable. Results on the immediate interpersonal level have been demonstrated (both here and elsewhere). Results on the organizational or community level have yet to be demonstrated. There is clear potential for replication of some procedures of this project on any level with a variety of populations.

Through the demonstration of alternatives, and via personal experience with alternative modes of organizing and educating community groups and agencies, the project is beginning to discover what is possible. Agencies are beginning to acknowledge neglected segments of the population; the focus of responsibility, personally and institutionally, is becoming more clear.

Following a change of project leadership and building on knowledge gained in the first two years of operation, a shift in direction was instituted in the fall of 1972. The project will continue to provide workshops for identified target populations. Currently the emphasis is on the interpersonal model. Instruction is based on the following assumptions: (1) personal participation is at the core of human relations training (people learn ways of relating, not isolated skills), (2) one of the best ways to learn a behavior is to practice it, and (3) in order to learn a behavior, teach it. Currently the project is emphasizing the development of a staff for the purposes of providing human relations and group leadership training within existing agencies and for community development.

Training is conducted in small groups (8 to 12). The group is regarded as a natural social unit for the exploration of self and for interpersonal experimentation. Observation and the use of the senses are emphasized. The two primary processes dealt with are communications, i.e., the use of specific verbal forms and their interpersonal consequences, and awareness. Awareness is considered essential for contact and communication. Behavioral goals are built around attention to and a focus on obvious and immediate behaviors. Though specific topics are dealt with, there is no systematic preplanned curriculum. Experiences are designed to transmit a process orientation to human functioning. Some topics and processes covered include the following: Attention-Awareness Continuum, Put Downs, Thinking-Feeling Split, Responsibility, Competition-Cooperation, Here and Now versus Then and There, Unfinished Business, Energy (flow and blocks), Person Centered Language, Family Relations, Learning (reinforcement and frustration), and Confluent Education. Working directly with body cues is also dealt with.

One of the greatest strengths and innovations of this project is the use of nonmental health professionals and paraprofessionals as community leaders and group leaders. This immediately "upgrades" the participant and keeps the focus of activity and responsibility in the local community. Maintaining the participants in training groups and putting them into field placements as soon as possible speeds up the training process, and provides supervision based on immediate personal experience; a co-leader model is also encouraged.

Training of Medical and Clergy Educators in Sex Education

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MH12849 1972–1975

Objectives

This program has four major general objectives: (1) increasing the manpower pool of medical and clergy educators trained in the areas of sex and marriage counseling (continuing education activities with family planning workers in developing comprehensive approaches to family planning counseling and in developing inservice sex education training programs are being supported by an additional grant from NIMH); (2) increasing the number of medical schools and seminaries teaching sex and marriage counseling; (3) increasing the number of consultations for program development requested by medical schools, seminaries and individual teachers; and (4) aiding in the development of several models of teaching in medical schools and seminaries.

More specifically, the objective is to increase trainee knowledge and skills in the areas of teaching human sexuality. This goal involves not only imparting knowledge and skills but also increasing trainee comfort with his own sexual feelings, thereby increasing his ability to lead groups of students in discussions of diverse value-laden sexual attitudes and behaviors.

Methods and Content

In general, three educational methods are used in this program: seminars, workshops, and inservice training. Seminars involve the direct dissemination of knowledge through lectures, discussions, case demonstrations, audiovisual aids, and group discussions. Seminar content is derived via cooperative planning with trainees to meet their particular needs. Workshop experiences are used primarily to modify trainee attitudes. Attitudinal modification is accomplished by intensive group discussions of audiovisual materials involving stages of sensitization, desensitization and integration. Intensive inservice training is provided to develop trainee skills and professional competence in marital and sex counseling. Training methods used in this area include lectures, seminars, small group discussions, supervised clinical experience in sex and marital counseling, family life education and family planning.

Specific content areas covered by this program include the broad area of human sexuality, including physiology, behavior and attitudes; techniques of marriage and sex counseling; group dynamics; psychodynamics; psychotherapy, including aspects of behavior therapy and expressive psychotherapy; and family planning techniques. In addition, techniques useful to the development and implementation of family life education programs in schools or other agencies are considered.

Seminars are contracted with trainees to last varying lengths of time. Most frequently, seminars are held from 8 to 12 2-hour sessions; another format is 1 or 2-day 8-hour sessions. Workshops typically last for an intensive period of 3 days. However, provisions have been made for the organization of workshops lasting from 1 to 5 days in order to meet the specific needs of the various participants involved.

Students

Participants in the continuing education programs include medical educators, clergy educators, other physicians, nurses, social workers, public health personnel, paraprofessionals and indigenous workers. One 2-day workshop had 125 students of whom 30 were medical teachers, the rest nurses, social workers and other health professionals and nonprofessionals. Other separate workshops are planned for 30 physicians and spouses, for 35 clergy educators and their wives and for 20 medical teachers. Inservice training is planned for selected individuals for varying lengths of time, from 1 to 3 months.

Characteristically, potential students select representatives to meet with faculty to map out seminars and workshops. Several planning sessions are held prior to each workshop, each involving several of the trainees and/or the administrators of their agencies.

As may be seen, the training program serves an educationally and experientially heterogeneous group which is extremely difficult to characterize as a whole. Many are post-doctoral, but some are not even at the college level.

Program Evaluation

Each training program is evaluated after several stages, during and following training. Immediate reaction of participants to specific training situations is assessed during training, through both objective and short answer paper and pencil questionnaires. These questionnaires are used primarily to gather feedback on how relevant or useful specific training procedures are to the participants. Additional attitudes toward and knowledge about human sexuality are assessed prior to, immediately following, and approximately 3 to 6 months after training. Students and staff contribute to evaluation; staff in "post-training" sessions.

Replication of the program is possible in institutions which have skills in combining affective and cognitive learning and which have staffs large enough to carry out a program of this sort. Some universities and medical schools, even teaching hospitals, seem to be on the edge of developing these skills.

There are indications that the educational program has had the desired effect. First, the number of medical schools providing courses in sex education for medical students has risen dramatically. (The continuing education programs are only a part of a total effort this agency is making in this direction.) Second, the number of participants and workshop opportunities offered by the agency have consistently reached or exceeded expectations, thus implying the need for such training. Third, evaluation results, to date, indicate that participants have, by and large, been pleased with the training they received. Fourth, there is some evidence that the training experiences have liberalized attitudes and increased participant knowledge in the area of human sexuality. Finally, as was planned, the establishment of a national Center for Sex Education in Religion has already attracted additional financial support from the Clement Stone Foundation and the Boston Theological Institute.

The most significant change in the program relates to methodology of the workshop experience. This program developed the design which integrates experiential learning with cognitive learning by the combined use of films with small group discussions. This process is designed to modify attitudes and stereotyped thinking with respect to sex and, thus, renders our participants more educable for specific content learning.

The major strengths of the project are: (1) the broad range of populations that we deal with, ranging from medical educators, physicians and other health professionals to family planning paraprofessionals; (2) the broad variety of teaching techniques used, ranging from affective learning methods to lectures, audiovisual aids, etc.; (3) the meeting of an obvious need in the medical education of young physicians; (4) the increased dissemination of sex and marital counseling information to clergy; and (5) the alteration of attitudes towards sexual behavior and sexually loaded topics.

A major weakness of the program is the difficulty with respect to staff. Since a wide variety of programs are offered, it is a taxing workload on the present staff; it is very difficult to provide the present level of service in continuing education with the amount of financial support available. Also, because of the use of methods of affective education, which can be quite intense at times, there is the potential risk of provoking anxiety reactions in trainees who have problems and conflicts in the area of sexuality. It should be pointed out that this has not happened to date, and only represents a potential risk.

The innovative aspects of the program involve: (1) the types of students served; (2) the integration of affective and cognitive learning; and (3) the range of content from dissemination of basic information to the acquisition of teaching and counseling skills.

Continuing Professional Education in Aging

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Objectives

The general aim of this continuing education project is to sensitize members of helping professions to the mental health aspects of aging to deepen and broaden their understanding of, and ability to cope with, the mental health needs and problems of this segment of the population.

Specifically, the project utilized the medium of continuing education to educate helping persons in mental health programs of the aging; to make available current research findings to bridge the time gap between research and community needs in preventing and/or coping with mental health problems of the elderly; to provide information on the problems of mental health in aging in terms of community and individual process; to increase professional capabilities in dealing with problems by providing an interdisciplinary approach to basic information; to stimulate interest of pertinent organizations and deepen skills of helping persons in attacking mental health problems of aging members of ethnic and minority groups; to develop and make available teaching aids for use in continuing education with emphasis on mental health and aging.

The target groups are professionals engaged in helping the aged directly or indirectly, and persons not specifically trained for their helping roles.

Methods and Content

The project offers a wide range of training sessions, including 1 and 2-day workshops and institutes, 5 or 10-week or semester length seminars, and 2-week summer courses, as parts of a comprehensive integrated program. Community leaders and other caregiving individuals are involved in the development of these training sessions. Through utilization of the educational process, they also become involved in working toward more effective planning and delivery of mental health services for the aging. Committees composed of professionals and nonprofessionals determine the format, length, and general content or emphasis of each offering. These committees are mostly interdisciplinary, but some are drawn from single profession organizations, such as nurses, and others are drawn from groups of black elderly community members and those serving the black elderly.

The following training sessions were held during the period from July 1971 to August 1972:

Summer of 1971—Five 2-week courses, meeting 10 6-hour days, centered on these subjects: 1) an overview or survey course on mental health and aging; 2) psychiatric aspects of aging; 3) clinical psychology and aging; 4) social work practice and the older adult; and 5) milieu intervention with older adults.

Summer of 1972—Six 2-week courses, meeting 10 6-hour days, were addressed entirely to mental health and aging. Subjects 1), 2), 4), and 5), offered during the Summer of 1971 were again included, plus new offerings on ethnicity and aging and integrating geriatric concepts into the nursing curriculum. In addition, substantial mental health focus was built into eight other 2-week courses offered by the Center. The eight courses were: concepts and issues in gerontology; biology of aging; environmental influences on behavior; sociology of adult life and aging; social psychological aspects of dying and death; aging and the family; behavior, brain function and aging; and current issues in the study of leisure and aging.

Workshops/Institutes—A total of 20 were completed and the planning for a number of others was brought to the point of implementation (held or scheduled for the year in process). Included were: (1) two 2-day meetings (one in Los Angeles, one in Palo Alto) on "Confrontation with Dying"; (2) two 2-day workshops on "The Psycho-Social Needs of the Aged: The Nurses' Role" (one in Los Angeles and one in Palo Alto), followed by five additional 1-day workshops on questions of what nursing training programs in Southern California are doing in the field of mental health and aging, what the role in this field should be of nursing training programs, and communications between nurses and older persons; (3) four 1-day workshops, over a 4-week period, on "Community

Services and the Black Elderly," including an examination of social and protective services, differential use of time, physical and mental health services, and social policy which facilitates services; (4) a 3-day institute developed with the help and advice of the project's Advisory Committee on the Mexican-American Aged, identifying (in English and in Spanish) specific needs which then were considered in four training workshops for persons providing health services to the Mexican-American elderly; (5) a 2-day institute on "Housing for the Elderly" which drew housing developers from building and industry, administrators of convalescent homes, and housing program consultants and administrators; and (6) a 1-day session on "Mental Health and Mental Illness" conducted by one of the summer session psychiatric faculty, in response to numerous requests for the session.

Three semester-length courses for post-baccalaureate degree students (30 to 38 hours) included: "Public Policy in the Field of Aging," "Social Adaptations in Aging," and "Theoretical Bases of Social Adjustment in Aging." In addition, with the aid of grants supplied from public and private sources, three other training projects were initiated: a 10-week seminar on "Institutionalization and the Older Person" for administrative and supervisory personnel of institutional facilities of various kinds; a week-long series of area symposia in four separate areas for adult educators and recreation workers; and an institute on utilization of volunteers. All three have demonstration components with the aim of developing models for training.

Students

More than 5,000 students attended one or more of the continuing education offerings. Data are not at hand, as yet, as to the number from each discipline involved in each of the separate undertakings. However, they include nurses (supervisors, administrators, directors of training, educators, practitioners), physicians (general practitioners and various specialties, including psychiatry, internists, gerontologists), social workers (with and without professional education), psychologists, churchmen, recreation specialists, nursing home administrators, public health personnel of various classifications and disciplines, administrative personnel from public and private organizations, civic leaders interested in aging, and others. For the most part, the students already had terminal degrees in their own fields of interest/practice, but few had prior training either in mental health or aging or both. The size of the elderly population and the continued need for manpower in this area points to a growing rather than a diminishing population of potential trainees.

Program Evaluation

Every session has been evaluated by each participant—student, faculty, planners. These evaluations are used to shape the direction of subsequent offerings, although the training design has not been basically altered. When the project has been concluded, there will be a followup study for evaluative purposes. The program lends itself to replication, as witness the fact that some offerings have been repeated successfully when requested in other States and communities. That there has been a positive impact on the community is evidenced by the growing demand for consultation and institutes and the increasing number of attendees referred by other participants. The consultations demonstrate an enhanced sensitivity to the mental health needs of the elderly.

Major strengths of the project lie in the fact that it provides an uniquely interdisciplinary responsiveness to community needs long ignored and about which there is relatively little shared knowledge. The project has fostered community involvement in identifying the needs, and feed-back about the efforts to meet these needs. The strategies for development of the continuing education offerings permit products of these offerings to be incorporated into the public and private health and welfare fabric of the community.

Certain difficulties are encountered by the project because of the paucity of competent trainers in the subject matter of the field of aging in general and in the area of mental health and aging in particular. This problem is exacerbated by the limited availability of trainers with techniques and strategies in continuing education for mental health and the aging. As a consequence, considerable staff time and resources must be invested in developing and/or attracting competent trainers in this important but neglected field. To a considerable extent, this weakness is compensated by the fact that the University of Southern California has one of the few graduate programs in science that stresses aging and a School of Social Work with strong commitment to the fields of aging and mental health. The Center has been able to draw on both to the advantage of the project and the achievement of its aims.

Continuing Education–Multidisciplinary

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Background and Objectives

This project, conducted by the Mental Health Program of the Southern Regional Education Board, grew from a concern about the fragmented and spotty practice of continuing education programs within the State mental health and mental retardation programs of the 14 southern States. While there were many programs going on within the institutions and community agencies under the jurisdictions of the State mental health or mental retardation programs, there was seldom any person or office concerned with how these various continuing education programs were planned, conducted, evaluated and financed. There was almost total lack of coordination of these programs; few were evaluated; most were not interdisciplinary, and some were promoting practices that were actually contrary to the overall objectives of the State programs.

This project has as its objectives: (1) to define the roles and functions of a State-level office of staff development—especially in the area of continuing education, (2) to improve the knowledge and skills of persons charged with these responsibilities, (3) to identify and define some of the techniques and problem-solving alternatives to achieving more efficient staff development and continuing education within the State mental health systems, and (4) to encourage and assist the State mental health and mental retardation agencies to establish offices of staff development with concern for continuing education.

The major target persons of the project are the State commissioners of mental health and mental retardation themselves, and the persons they have identified to be their programs' delegates to the Conference on Continuing Education Opportunities, which has been the major advisory and planning body for the project, as well as the major working force. Each State commissioner was originally asked to name that person from his agency whom he felt would have the most concern and responsibility for State level staff development and continuing education programs to serve on the project's Continuing Education Opportunities Conference. The fact that the nominees were a diverse group ranging from training officers and personnel officers to directors of psychiatric nursing and directors of psychiatric residency training was a dramatic manifestation of the fragmented state of the art which the project was designed to remedy.

Method and Content

The methods have consisted of ongoing working meetings and task force sessions of subgroups of the full conference, and surveys. Some of the working meetings have been essentially educational, such as the one to learn more about adult educational theory and methods or the one to learn about simulations and gaming as experiential learning techniques—especially to get at value and attitude hang-ups.

Most of the meetings—especially those of subgroup task forces—have been task oriented and designed to develop guidelines for what State level offices of staff development might do to best serve the mental health manpower development needs of the State mental health programs. One such task force looked at the basic roles and functions of such an office (i.e., assessing the needs for education programs, finding the funding, helping with arrangements and educational materials, facilitating arrangements with higher educational institutions for instructors, assisting in evaluation, and making programs interdisciplinary). Another task force explored issues and identified alternatives for the structure and administrative relationships of an office of staff development (i.e., where it might be located in the central office staff, the staffing patterns, relationships to the institutions in the field, relationships to umbrella human resource agencies, and Civil Service systems). Another group explored ways in which such an office of staff development might be used as a management tool in program planning, program development and evaluation, as well as in clinical mental health training. When a State mental health program sets new policies (i.e., for geographic units, for regionalization, and for uses of new levels of workers) how can it use the staff development system as a tool for bringing about these changes in the system?

The results of these deliberations were published in "The Office of Staff Development in a State Mental Health Agency" which has been widely circulated throughout the region and the nation.

Surveys were made of each State to determine what training and continuing education programs existed and how they were planned, conducted and evaluated. The commissioners were surveyed in person for their opinions regarding the needs, the problems and their recommendations for how best to proceed. These issues also were discussed with the commissioners as a group in the Commission on Mental Illness and Retardation of the Southern Regional Education Board. A task force of the Commission on Mental Illness and Retardation and the Conference on Continuing Education Opportunities is presently preparing recommendations to NIMH for how a program of State grants for manpower and staff development might best be structured.

Students

There are no students of this project in the traditional sense. The participants have been the commissioners themselves and the members of the Conference on Continuing Education Opportunities already described. At some of the educational meetings there have been other attendees such as the directors of other continuing education programs for mental health workers throughout the South, and staff persons from NIMH regional and central offices.

Program Evaluation

Evaluation is partly based upon the products of the project (i.e., "The Office of Staff Development in a State Mental Health Agency" and the recommendations to NIMH for a grant program in staff development). In part, evaluation is by assessing whether commissioners and the members of the Conference on CEO have a better knowledge of issues and ways to deal with CEO. In large measure, evaluation is by determining whether such offices of staff development have been established and are functioning.

This project might well be replicated in other regional compact organizations—especially the Western Interstate Commission on Higher Education or the New England Board of Higher Education. It might also be replicated in various regional offices of NIMH.

The impacts to date are that the publication "Office of Staff Development in a State Mental Health Agency" has been widely distributed in the South and throughout the nation. A resolution has been sent to NIMH urging a program of State grants to facilitate manpower and staff development within State agencies, and meetings have been held with NIMH officials regarding such a possibility. At least seven State mental health or mental retardation agencies in the South have established staff development offices or have substantially broadened the responsibility that formerly existed.

The project initially had difficulty in getting off the ground because of the wide differences in professional orientation and responsibilities of the members of the Conference on CEO. Also, there was a great deal of turnover of people. The group has become much more cohesive. The new persons recently named to staff new offices of staff development will provide more turnover, but it is a welcome kind of turnover for it allows us to turn now to implementation more than planning and development of guidelines.

The work done so far provides a clear concept of the why, what and how of staff development upon which State commissioners, legislators, budget directors and staff development officers, themselves, can move ahead. Until now there has been no such concept. Each person had to muddle through for himself.

SREB, itself, will continue to have regular meetings with the commissioners of mental health through the CMIR which is supported by the States. However, a grant proposal is pending to move strongly ahead with implementation of the already developed proposals and to further develop procedural alternatives for some of the major guideline areas. This proposal would also establish a closer tie to all continuing education directors of individual institutions and community mental health/mental retardation centers in the work of the Conference.

Human Relations Training and Community Mental Health

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MH12089 1970–1975

Objectives

In this year-long series of weekend continuing education programs for community organization leaders, police officers, social workers, key clergymen and school personnel, the main objective is to assist participants learn how to handle the emotional and psychological problems arising from race conflicts in a high-tension community.

The overall continuing education objectives are to: (1) provide data on the psychological and psychiatric aspects of race conflicts; (2) develop awareness of and sensitivity to symptoms of neurotic and psychotic disturbances incident to and associated with race tensions, prejudices, violence, civil disorders and urban riots; (3) introduce participants to skills needed for diagnosis, counselling, therapy and referral of disturbed individuals; (4) help professionals see how racial attitudes and values affect their dealings with persons of different racial backgrounds; and (5) develop coping mechanisms and skills needed by professionals in handling emotional and mental problems associated with racial change.

The specific objectives in terms of measurable knowledge, skills and behavior change are to: (1) inform participants about the nature, extent and meaning of the racial conflict problems within the local community; (2) lessen interracial hostility, aggressiveness, belligerence and antipathies by reorienting the participants, both black and white, to regard each other as human beings faced with the need to resolve the human problems that confront them; (3) develop skills in problem-solving by practicing these skills on solving the problems of racial conflict that divide the participants and the community; and (4) intensify other conflict management skills such as the ability to work cooperatively with other individuals and groups in resolving community and individual crises.

Methods and Content

The program emphasizes skill-development in problem-diagnosis, problem-location, problem-solving, group discussion and development, particularly in interracial or bi-racial groups; communications, listening, interviewing, counselling, and conflict-resolution skills; role-playing, critical-incident analysis skills; and skills in handling frustrations, reflecting feelings, handling desegregation incidents, and generation-gap bridging. Methods include mainly learning-by-doing in small, biracial learning and discussion groups, at learning stations in the learning center arrangement, with visual aid input, and a minimal use of lecture input. Community crisis simulations and games are also used, as well as sociodramas with discussions and interpretive sessions.

Program content is determined by use of a problem-posting method with each group. This is followed by a priority rating of the problems posted, in which the participants rank the problems in the order of importance as they see it. Subsequent weekend programs are scheduled to deal with these problems. This decisionmaking process has resulted in coverage of these topics in discussions: general race-conflict community problems; school desegregation problems in the classroom; school social activities; taboos on co-racial courtship and marriage; school busing problems; disciplinary and delinquency problems of youth; police-youth conflicts in desegregated neighborhoods and schools; background for current problems in past conflicts; the Black Heritage in America; separatist movements among black extremists; racial unrest and riots in urban areas; emotional aspects of racial conflicts; mob psychology and individual emotional disturbances; value conflicts in the USA between democratic ideals and racial practices; programs for betterment of race relations and police-community relations.

The individual institutes operate for 40 hours, 10 hours per weekend, for four weekends spaced over a 2-month period.

Students

The first 2 years' series involved 293 persons, a majority of whom were school personnel, owing to the desegregation plan that went into operation in 1970. These included 1 school board member, 6 administrative and supervisory personnel, about 24 principals, and 115 teachers, 6 counsellors, and 3 attendance workers. Only about 16 key clergymen and 6 law enforcement officials were involved, along with about 18 social workers, and about 50 community organization leaders. By race, 54 percent of the group were white and 46 percent were blacks.

The trainees were above average in their community organization participation patterns. Instead of just belonging to a church and one other organization, the majority belonged to three or four organizations that are active in the local community, especially in contact with youth. They also represented a wide variety of occupations in addition to their community organization work: health professionals and hospital workers (6); banking and insurance professionals (6); research associates and systems analysts (2); engineers and architects (3); local small businessmen (3); newspaper editors (3); and "housewives" (18).

Program Evaluation

The program utilizes a standard participant reaction sheet or sample participant reaction to the program.

The Human Relations Training Institute could be replicated by any health education training center where the combination of professional skills required are found in the staff and the visiting consultants. The training director should have a degree in sociology, social psychology, or education with a heavy emphasis on minority education, and have postdoctoral training in contemporary methods of adult education in the handling of large and small group institutes. He also should have special training in general management, problem solving, decisionmaking, oral communication, group leadership, conflict management, race relations, and community organization.

The project impact has been observable in the lessening of conflict within the community and the schools even with the massive desegregation process, as more teachers and parents are subjected to the training and more administrative personnel from the central school board administration are reached by it. One of the trainees has been in charge of the public school teacher and staff training program for handling the racial conflict in the schools. Thanks to her participation in the program she has been able to bring to the majority of the 2,000 teachers in the system the kinds of training she first became acquainted with in the institute. This program has resulted in more professional handling of school racial conflicts and tensions through the organization, development and activities of the bi-racial councils set up in each of the schools. These are supplemented by more productive problem solving and coping techniques used by the school administration in place of the old heavyhanded, riot-squad and repressive police methods previously used.

The most significant change has been the replacement of programs headed by outside experts with programs involving maximum participation by all participants in their learning experience. During the first year of the program it was felt that bringing in the high prestige and nationally known persons was essential for the maximum impact of the program. It was found, however, that these experts tended to overawe the participants and to inhibit discussion, dialogue and free surfacing of conflicts. Experience during that first year revealed that participants came to grips with their problems better if they were given the chance to learn from concrete experiences with reflective observation and active experimentation rather than with the abstract type of conceptualization usually utilized by the visiting experts. A whole series of flexible role plays, simulations, case situations and live demonstrations has been developed for different phases of the program and different types of participants.

The participants tend to evaluate the practical skill training in problem solving and conflict resolution as a strong point of the program. Many, for the first time, are brought into face-to-face, across-the-table confrontation with members of the opposite race, with a view to listening and understanding rather than intensifying fears, hatreds, hostilities and conflicts.

The major weakness of the program is the inability to schedule it at a time when all major groups of participants could be represented in equal numbers. Weekends tend to be inappropriate times for law enforcement officials, as Friday nights and Saturdays are the busiest of the week. It is also difficult for clergy to attend on Fridays and Saturdays.

The over-representation of school personnel is regarded as a weakness, since they are identified with academic matters, even though involved in many community organizations. Though this gives the program a chance for greater impact on youth because school personnel tend to deal with more youth than any other group, it is felt that the learning experience would be more valuable if a better participant mix could be maintained.

This program is considered by staff to be an innovative approach to continuing education in mental health since few mental health training programs focus on racial psychosis, though racially engendered neurotic fears are a major mental health problem. Emotional upsets occurring because of racial fears, hostilities, and conflicts are among the most wide-spread mental health problems in this community.

Mental Health Consultation Continuing Education Program

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MH11706 1969–1973

Background and Objectives

The terminal goal of this 4-year interdisciplinary learning experience was to establish regional satellite mental health consultation continuing education centers in Mississippi, Kansas, Texas, and Missouri. These centers are currently planned, implemented and evaluated by mental health professionals, who participated in the Tulane University, Mental Health Section, core program.

A 1968 survey revealed that mental health consultation was the least understood essential service offered by community mental health centers. This finding has been reconfirmed by the recent Nadar Report. Mental health consultation can be described as the consultant's effort to encourage a self-motivated behavioral change in the consultee's objectivity, problemsolving ability, and work competency.

For the past 8 years the Tulane University Mental Health Section has conducted a local mental health consultation continuing education program. This program has prepared over 70 mental health professionals for consultation roles with community "care-giving" agencies. Concurrently, a related learning experience has prepared supervisors for these consultants. In 1969, through funding from NIMH, a similar program was initiated on a regional level. By late 1972 this project had prepared 21 professionals for mental health consultation roles, 11 for additional supervisory roles, and four as directors of the satellite education centers.

The purpose and learning objectives for the program have varied and overlapped during the second and third years of the project because the program has been preparing key professionals for three different sequential roles. The basic core role, however, for all program participants is that of a mental health consultant, and the purpose of that learning sequence (Phase I) is to provide an interdisciplinary learning experience for participants which would form a broad base for integration of the multiple factors involved in the mental health consultation process. The objectives of Phase I are to provide an opportunity for participants to: (1) demonstrate their standing of the basic principles and theory of mental health consultation through participation in a selected consultation experience; (2) apply skills in problemsolving by assisting consultees to deal more effectively with problemsolving; (3) identify and resolve some of the role and status problems in offering mental health consultation to professionals of other disciplines; (4) demonstrate creativity and flexibility in dealing with viable mental health consultation problems; (5) compare and contrast the differences in activities performed in consultation, supervision, education, and psychotherapy; (6) clarify and apply their understanding of theories and concepts relevant to consultation practice, such as: role theory, systems analysis, group process, planned change, administration, and community organization; (7) expand the communication and human relations expertise of regional professionals and allied professionals (consultees); (8) add to the existing body of knowledge related to the mental health consultation process; and (9) utilize evaluation tools which will help to determine the effectiveness of the training method, the consultation service, and the supervision process.

Participants and Design

During the academic year, 1969–1970, a multidisciplinary group of eight professionals (psychiatrists, social workers, nurses, and psychologists) from Texas, Missouri, Kansas, Tennessee, Mississippi, Florida, and New Mexico was selected to participate in Phase I of the program. The program design involved five intermittent weekend visits to Tulane University for concentrated 2-day seminars. Simultaneously, each participant selected an organization in his own community for a consultation practicum. The first Tulane visit provided time to consider theoretical issues and examples of mental health consultation. Once this was accomplished, the individual consultation practicums became the focus of study and analysis by the seminar group. Supervision, which is viewed as the cornerstone for learning the consultation process, was also offered to each participant through a correspondence-telephone system, as well as upon each Tulane visit.

The next academic year (1970–1971), Phase I program activities were repeated for a newly selected group of eight regional professionals. Concurrently, six participants of the 1969–1970 year returned for a supervisory experience (Phase II). In the 1971–1972 year, four professionals who had completed both Phase I and Phase II activities were prepared to assume the Director's role of a satellite education center (Phase III). Additional members of their core faculty teams were offered consultation and supervision experiences as needed for individual learning during this same time period.

By late 1972, the four satellite centers were operational (Phase IV). These centers are currently preparing approximately 30 local professionals for mental health consultation roles.

This project was originally designed by two Tulane faculty members (psychiatrist and nurse). When NIMH funded the program, five additional professionals (social workers and psychiatrist) assumed faculty roles and became involved in the decision-making process for program planning, implementation, and evaluation.

During the early part of the first year, decisionmaking was more centralized to the Tulane group. But, as the year progressed, participants were encouraged and were offered opportunities to take part in program decisions. During the next 2 years, there was more active mutual decisionmaking operational through a telephone conference system and correspondence. By the third year, four Tulane people were phased out of the project and the regional group assumed even greater responsibilities for decisions. Currently (Phase IV), decisionmaking is localized for each satellite center operation and Tulane faculty remain available, upon request, to function in consultation and/or resource roles.

Program Evaluation

During the 1969 planning and recruitment phase of the project, six instruments were designed to record and analyze the mental health consultation process and to determine the effectiveness of the education program. Analysis of data collected by three of these instruments reflected the quality of consultation services and also showed a high level of agreement between the consultant and consultee pairs on comparable qualitative items. These findings have been reported in the literature. Our initial efforts to evaluate the process and outcome of mental health consultation have been offered to the satellite centers as a base for more scientific, experimental research designs.

Several factors in this program are indicators of its uniqueness and its perpetuating quality. Of major importance is the spin-off to other States where the satellite centers are conducting similar training programs and spreading influence into their own and nearby States. The transferability of this type of program is evident. A selected group of professionals also have had an interdisciplinary learning experience which in most cases has been unique for them. At the same time, 21 community organizations had the opportunity for mental health consultation during the first 3 project years, while 38 organizations are currently receiving this service. Two other innovative characteristics of this program for continuing education are: (1) extensive use of the group process and, (2) focus on intermittent seminars with ongoing field practice and supervision. The factor of time in the development of group cohesion and the opportunity for field experience between learning sessions were considered most important ingredients for learning. This continuing education model could be utilized for teaching other content areas which involve practical experience as well as cognitive input.

Although no major weaknesses have been noted, recruitment could be improved for future, similar programs in order to be acquainted with participants. The element of supervision could be strengthened, along with the evaluation design.

Advanced Study Continuing Education in Mental Health

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MH12406 1970–1973

Objectives

The Center aspires to four effectiveness areas: organizational effectiveness, staff effectiveness, continuing education specialist effectiveness, and institutional linkage of continuing education. In the area of organizational effectiveness, the general objectives are to improve organizational effort, effectiveness, and efficiency. Specific objectives are to help top and middle management of major psychiatric facilities develop the skills necessary to implement management-by-objectives plans in their organizations.

Methods and Content

Methods utilized include a series of lecture and workshop sessions with top and middle management. Content concerns theory and practice of the management-by-objectives approach. The time requirement is approximately 4 days of didactic training followed by work performed by the management group, written reports being submitted to the Center. Center staff is available for consultation during this implementation period. A 1-day workshop follows within 6 months of the first meeting.

The general objective in the area of staff effectiveness is to help the staff achieve training objectives derived from an analysis of performance or from the observations of Center staff regarding "universal" training needs. Specific objectives concern knowledge, attitudes, and second skills related to particular organizational needs. Some programs have been developed for repetitive offering; for example, introductory behavior modification and cost-finding.

Ideally, the programs have four phases: pre-institute preparation of up to 3 months depending upon the particular program; an institute of 1 to 3 days in length; "back-home" implementation, length depending upon the nature of the learning task; a workshop of 1 or 3-days' duration where students present their implementation experiences and are expected to learn from their peers as well as from the instructor.

In the area of continuing education specialist effectiveness, the general objective is to help trainees develop competence to plan, implement, and evaluate training programs. Specific objectives are to help students develop knowledge, attitudes and skills relevant to determining training needs and formulating objectives, selecting relevant content and appropriate training strategies, planning the organization and logistics of training, and applying evaluative techniques.

Methods and content are essentially

that described under staff effectiveness. Content covers the process of analysis of performance, economic analysis of training as a solution to performance problems, formulation of training objectives, selection of content and teaching strategies, learning objectives, selection of instructional media, and evaluation of learning.

The general objective in the area of institutional linkage of continuing education is to make continuing education an integral part of professional educational programs in the collaborating institutions. Specific objectives are to align the training objectives of continuing education programs with those of the regular degree programs of the collaborating institutions, and secure for continuing education institutional resource allocations and manpower facilities and financial support.

In 1973, the Center expects to establish a series of subcommittees by discipline, each of which would have the task of formulating criteria for the allocation of learning objectives to continuing education and to professional education programs. Each subcommittee would be composed of representatives from the sponsoring board, professional education programs, practice and professional membership associations. The 2-year process would culminate in a national conference, the outcome of which would be a set of guidelines for the development of a continuum between continuing education and regular programs of professional education.

Students

From June 1971 to July 1972, the Center sponsored or co-sponsored 20 training events involving about 1,400 participants, approximately evenly divided among the major psychiatric professions, with a substantial number of paraprofessionals. Exact data on disciplinary affiliation of the trainees is not available. For many of those attending, the program was their first intensive opportunity to prepare themselves specifically for organizational tasks, with involvement of all levels of the organization where they were employed. The potential target population is about 8,000 staff members of 266 facilities in 8 Southeastern States.

Program Evaluation

The Center considers its organizationally focused programs to have been successful, if management-by-objectives is fully established. Staff effectiveness training programs are evaluated with respect to the achievement of specified educational objectives by participants.

The Center believes that this program can be replicated at local, regional, and national levels. Its staff has been asked on several occasions to describe the program.

With respect to impact of the project, the Center believes that the management-by-objectives training has resulted in clarification of objectives by participants and has enhanced their ability to evaluate effectiveness and efficiency, discover gaps in objectives and programs, clarify responsibility and alignment of objectives between various work units in their organizations, and improve their supervisory procedures. The Center has not assessed the extent to which these benefits have resulted in improved mental health of the clients served by the particular organization. Similarly it does not have definitive data on the impact upon the organization of any improved competence developed by participants in the training program. Efforts so far to link continuing education with the regular program have resulted in the use of the Director of the Center as an instructor in the basic program and on various professional program planning committees in the collaborating institution.

The major change that has occurred since the beginning of the program has been in the increased effort given to organizational development issues as well as in the focus upon the development of four phase training programs. The latter have proved somewhat difficult to implement unless the program is geared to a specific organization whose supervisory staff can be used to monitor the preparation process. When training programs are given for participants who represent a variety of organizations, the preparation is difficult to supervise.

The Center considers the organizational focus and the systematic development of training programs to be its major strength. A major weakness is the difficulty of finding instructors who can adjust their teaching techniques to characteristics of the target population. Continuing education probably needs a staff of its own, rather than depending upon an instructor who may tend to see participation in continuing education programs as not central to his teaching responsibilities.

Continuing Education in Mental Health –Interdisciplinary–

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Objectives

This training program provides continuing postgraduate education to professionals in a variety of mental health disciplines and related fields, such as physicians, psychologists, social workers, educators, nurses, and clergymen. The specific objectives of the program are, first, to increase and broaden the clinical skills of professionals in mental health clinics and agencies practicing traditional psychotherapy, Pastoral Counseling, Family Counseling, Crisis Intervention, Educational Counseling, etc. and, second, to increase the knowledge of mental health principles of key professional groups who have an important effect on the community, such as teachers, physicians, policemen, lawyers, etc.

Methods and Content

The training is conducted in small group seminars led by psychiatrists. Specific content areas vary with particular professional groups and their specific needs. These include psychotherapists, short-term therapy, therapeutic emergencies, destructive acting-out, therapy of addictions. Others include delinquency, drug abuse, student violence, suicide, child abuse, marital problems. The time sequence and course hours also vary. Weekly seminars of 1½ hours duration are held for periods ranging from 10 to 36 weeks.

Students

Participants in the program include 12 physicians, 8 pastoral counselors, 12 psychologists, 18 social workers, 30 police officers, and 15 visiting nurses.

Most students in all categories have had some previous training, with the exception of police officers. This latter group has had no formal exposure to education in the mental health field. Approximately half of the physicians have had some postgraduate education in psychiatry. All of the members of the pastoral counselor's seminar are graduates of university pastoral counseling programs with the equivalent of an undergraduate major in psychology. Most psychologists are Ph.D. level with a few at the M.A. level. All social workers are at the M.A. level with most having ACSW status. The visiting nurses are at B.S. and M.S. levels; all have had undergraduate training in mental health.

Program Evaluation

Programs are planned at meetings of the Program Director, prospective instructors, a coordinator for the particular discipline or field involved (usually university department members for social workers, psychologists, physicians and pastoral counselors, and visiting nurses; and the Commissioner of Police for the police officers) and representatives of the trainee group. Evaluation is performed by the course coordinator from the particular discipline, the instructor, and the Program Director. One trainee is selected from each seminar to poll the students' reactions and represent them at the evaluation meeting.

This program has stimulated considerable interest among psychotherapists to increase their skills and to broaden their basic knowledge. News of the program was initiated by questionnaires and announcements sent through the mail, but has since spread through active participation of mental health agencies. These agencies, in turn, have been able to upgrade the quality of their services as a result of seminars attended by their personnel. Course coordinators from such disciplines as psychology, social work, pastoral counseling, and nursing have been able to feed back valuable suggestions to their graduate schools regarding curricula and clinical experiences as a result of participating in the seminars. They have been able to delineate deficiencies in their practicing graduates. The Police Academy has incorporated certain aspects of the seminars into their regular curriculum.

The only significant change in the program has been the increased use of professionals from various disciplines as course coordinators, to assist in the planning and evaluation of seminars, rather than as co-instructors.

The major strength in the program comes from being able to bring the highest quality instructors to groups of mental health professionals in small, intensive seminar groups. These instructions would not otherwise be available to professionals working in agencies because of the cost. By keeping the seminars small the program can have maximum impact on the participants. By pinpointing an intensive effort at key mental health workers, the program's training efforts can be spread through the therapy and supervision they carry out at their agencies. This approach, along with the basic goal of the seminars—to translate psychiatric and psychoanalytic theory into practical application with the types of patients seen at agencies—are the most unique aspects of the program. Its major weakness is the difficulty in obtaining the type of instructors qualified to carry out this approach. They are few in number and in high demand. The small seminar approach also limits the number of professionals that can be directly affected.

Continuing Education for Mental Health Personnel

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MH10758 1968–1974

Objectives

The ultimate objective of continuing education in a professional field is to generate needed change in that field by disseminating new knowledge among its members. This project's primary objective is to promote the development of cooperative, interdisciplinary systems of continuing education which will be accessible to mental health workers and their citizen allies in the Western United States and flexibly adaptive to their unique circumstances. A major working premise is that such a system, or series of sub-systems, should be based upon joint planning between educators and practitioners in the field. This attempt to link academia and the field is currently modeled on efforts to link five vested interest groups, each with its own perspectives: (1) State leaders in mental health systems, (2) community mental health leaders, (3) the four regional offices of HSMHA in the West, (4) graduate schools and other foci for continuing education resources, and (5) the major minority-group mental health workers in the west (largely Chicano, Indian, and black—and largely untouched by traditional continuing education in the past).

As these interest groups are linked into working consortiums, regional groups, and time-limited task forces, the development of collaborative systems can be tracked and hopefully measured in ways which will shed some light on the process of system-building in continuing education between diverse vested interest groups.

Methods and Content

Three methods are employed:

1. Consortia and State/regional inter-agency groups focusing on continuing education needs and the cooperative use of continuing education resources are developed through negotiation and small-group meetings with WICHE staff serving, usually on a temporary basis, as neutral conveners.

2. Institutes, workshops, and task forces are developed for key leaders in mental health treatment agencies. These activities are usually in the form of small-groups (15–25) meeting from time to time over several years, each meeting a short intensive 2 or 3-day session. Game simulations, group agenda-building, presentation of problems by participants, and preparation of position papers are typical methods. An adult education model ("androgogy" in Malcolm Knowles' quaint phrase) is almost exclusively followed, since most participants in these sessions are leaders in their own right, each with considerable expertise of his own on much of the topics at hand. Topics include: management and organizational problems, role-changes among professional and paraprofessional staff (and citizen boards), new methods for "prevention" (community organization, efforts to deal with racism, etc.), and response to new kinds of community problems (drug problems, inter-ethnic fric-

tion, crimes of violence, unmet needs of children, etc.)

3. The use of surveys and the development of a taxonomy of evaluation methods are presented in order to assist continuing education program directors to track the directions and impact of their programs.

Participants

In four years, this project has involved some 1,394 participants (about 500 individuals). About 70 are persons with a major interest in continuing education programs, including continuing education project directors from all four of the core mental health disciplines, new careers training directors, and staff development leaders from local and State agencies. Other participants have ranged from highly trained professionals (State-level commissioners, directors of community mental health centers, etc.) to individuals with little formal training (new careerists, paraprofessionals, ex-addicts, alcoholism counselors, and citizen board members). Minority-group mental health workers in the West frequently lack formal credentials—but many are emerging as key leaders and taking part in regional-level institutes.

Program Evaluation

This project is attempting to assemble clearing-house data on evaluation methods now being used in the West. Its own methods have included "satisfaction" questionnaires, open-ended reaction papers from key participants, and the use of followup planning committees devising new institutes on the basis of previous participation. An instrument for CENP (Continuing Education Need Perception) is now being developed patterned on the Delphi method for developing consensus patterns among groups of professionals about their perceptions of future needs, issues, dilemmas. The thought here is that if an instrument capable of discerning shifting patterns of need-perception could be developed, it could prove a potent tool for evaluating whether perceived continuing education needs have been met over a period of time.

A methodology for efficient inter-agency collaboration on continuing issues is, in a sense, one of the objectives of this program. Whatever can be learned about this process is available for the use of similar efforts elsewhere—including statements of goals, consortia minutes, evaluation instruments, etc. Game simulations (such as the West Nacirema County Game, a mythical western county, complete with map, demographic data, and assorted game rules) have been shared, along with position papers on such issues as the mental health problems of the urban barrio. Most institutes are not replicable exactly, because their very design has proceeded from their participants' contributions, but the methods hopefully are applicable elsewhere.

At this point, five continuing education consortia have developed, at least partially stimulated by this project, three of which focused on linking continuing education resources in major metropolitan areas, two on a state-wide basis. A series of five task forces have been developed on Chicano continuing education needs. A small group of black mental health workers has been convened three times on issues unique to the black mental health worker in the West. A small Indian group has been formed, and two small groups of community mental health center directors. A number of regional or subregional (two or three States) workshops have been convened, focused on such issues as continuing education needs, rural mental health models, need assessment at the catchment level, and the use of paraprofessionals.

This project began with the knowledge that it somehow had to serve from 11,000 to 15,000 mental health workers and their citizen allies in the West. This implied need for a selection process designed to involve key people, a focus on system-building, care to involve States with scarce resources as well as those relatively rich in resources, and use of convener skills to bring about collaboration between vested interest groups. Headway has been made on a number of fronts—but the West is a plural society with enormous social barriers between its major ethnic groups. It is beset with problems of geographic distance, sparse populations located in oasis-like cities at great removes from one another, and gross disproportions in resources—including education resources. The program believes a regional approach to these problems makes sense, has in part been vindicated, but must still cope with major problems.

Manpower Development for Program Analysis

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MH12786 1972–1974

Objectives

The general purpose of the program is to improve the delivery of mental health services by more effective program development at the local level. The broad objectives are to develop the capability of local clinics and centers to utilize data about the community, program management, and service programs and to provide program managers with access to this data. The project goals which are instrumental to the broad objectives and purpose are: (1) to increase the number of persons able to collect and analyze the data at the local level; (2) to improve the skills of the persons responsible for mental health program analysis and development at the local level; and (3) to increase the general use of data in local mental health programs.

In developing the program, certain assumptions seemed inherent in the situation. These were that program directors, board members, and staff want help in making program decisions; that data will be collected and used if there is sufficient skill available; that there is a way of training/educating those responsible for program development and program analysis; and that there are audiovisual techniques which are effective and efficient in continuing education.

Methods and Content

Training methods are in a developmental stage, but it is anticipated they will include workshops and experiential learning sessions, based on trainee defined issues. Specific content areas will be trainee determined but will most likely relate to identification of objectives, operationalizing objectives, identification of criteria, design of measures, instrumentation of data collection, analysis of data, interpretation of analysis, presentation of data, and use of data in decisionmaking.

As changes in skills are not usually accomplished by the lecture/classroom method, the program will focus on developing "educational teams" that would travel to the field to work on a problem faced by a mental health agency. An "educational team" might be composed of the following types of members: (a) the local agency person responsible for program analysis, (b) a State-level person responsible for data analysis in the State in which the agency is located, (c) a person from another WICHE State who has experience and/or common concern in the problem, and (d) a technical "expert" drawn from a university or other appropriate setting. The inclusion of the first two members of the team (a and b) is needed to help assure coordination between State and local programs. The inclusion of the other "WICHE State" member (c above) is aimed at providing another perspective on the problem and development of interstate sharing of information. The "technical expert" is aimed at providing methodological content, teaching, and curriculum development experience.

Students

Trainees will be multidisciplinary, representing a mix of professional, paraprofessional, and other personnel in local mental health service programs. Initial target groups include: a line staff of a CMHC, a citizen board of a CMHC, personnel of a State central office with responsibility for community services, and a group of persons responsible for program evaluation from several CMHCs.

Program Evaluation

Project evaluation is currently being designed to collect "feasibility" data and "service" data. Service data will include what continuing education services are delivered to whom, where, and with what effects. Feasibility data will include costs of delivering service, time required, and number of methods developed. Participant evaluation will include trainees' satisfaction, change in attitudes and skill. Methods for measuring behavior change for evaluation of effects are being conceptualized.

Replication of this program to other regions and/or target groups is clearly possible. It is hoped that the project will provide information about the effectiveness of training with each target group relative to implementation.

The potential strength of the project lies in providing training relative to current program problems faced by local mental health services which will increase the likelihood of application of learned skills.

Psychiatry–Continuing Education

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Objectives

For over 3 years the Division of Mental Hygiene has been implementing a Continuing Education grant to establish a closer working relationship with the University of Wisconsin-Extension. The grant seeks to develop a structure and a process by which Extension provides a broad range of continuing education services for the State mental hygiene system.

The Continuing Education Project has specifically focused on three objectives: (1) to provide a broad range of educational services to the county mental hospital system over Extension's Educational Telephone Network; (2) to establish a structure for providing middle-level administrative training to mental hygiene program administrative training in mental hygiene program administrators; and (3) to develop a system of staff development programs throughout the State that reflect the training requirements of comprehensive programs rather than individual professional disciplines.

Methods and Content

The project is now in its third year of using the Extension Education Telephone Network. This system provides two-way communication over a voice circuit to a network of subscribing institutions. Previously, the programs offered by Extension were designed for the staff development needs of a general hospital, and additional programs were designed and produced to meet the project's needs. With thirteen county mental institutions now subscribing, Extension is adjusting its program offerings to include specially developed programs for mental hygiene agencies.

The project has one year's experience in carrying out the middle-level administrative training program. This program is conducted on a regional basis, bringing together senior program administrators from mental retardation, alcoholism, and drug abuse programs. The training is a mixture of conceptual material and problem-solving activities.

The project has begun to develop a system of staff development coordinators, most of whom at present are based in the county mental institutions. The long-range plan is to develop, within each catchment area, a comprehensive staff development program under a single coordinator for the disabilities of mental illness, mental retardation, alcoholism, and drug abuse. Under another continuing education grant, a newly established Office of Continuing Education in Mental Health at University-Extension is assuming much responsibility for a long-range plan to train continuing educators in mental health.

Students

Slightly less than half of the county mental institutions are now subscribing to the Educational Telephone Network. In addition to the usual mental health professionals found in these institutions, there is a large aide staff and other support staff that the project tries to reach with appropriate programming.

In the administrative training program there is an established list of approximately 250 senior administrators. At present there is great diversity in their background, educations, and experience.

Staff has identified in different kinds of programs around the State about 20 training coordinators whom they are working with to develop as comprehensive staff development coordinators. Some are nursing inservice instructors who are broadening their range of responsibility and concern. Others are nonmental healthers with backgrounds in educational or related fields who have been hired under hospital staff development grants.

Program Evaluation

Because this project is to develop more services by University-Extension for the State mental hygiene agencies, one measure of its success is the number of dollars that these agencies spend for new Extension services. The number of dollars paid by the Division of Mental Hygiene to various departments in University-Extension for new educational services has increased significantly.

During the past 3 years, the Division and its related agencies have invested about $35,000 in the use of the Educational Telephone Network. Through periodic visits, mail responses, and annual workshops, county hospitals are providing constant feedback on their use of the Educational Telephone Network.

During academic 1972–73, the project is spending about $2,500 to develop educational programs for mental hygiene administrators. This sum is a subsidy which ensures the provision of programs designed especially to meet the needs of the mental hygiene agencies. Through regional steering committees staff is constantly evaluating the planning and carrying out administrative training.

A series of three institutes for mental hygiene staff developers is being carried out by Extension. These institutes represent a new service, new income, and a potential source of considerable new programming for the Extension.

During the life of this grant, it has frequently seemed that the biggest single obstacle to providing the range and quality of educational services demanded by a rapidly changing mental hygiene system is the narrow professionalism and organizational inertia of the academic departments within University-Extension. Another major obstacle is the organizational inertia of mental hygiene agencies in changing both roles and objectives to meet the needs of developing comprehensive services. One way to overcome these obstacles is to increase the knowledge of Extension faculty and staff about the present-day problems of the mental hygiene agencies, and to increase those agencies' awareness of Extension as a potential resource.

Continuing Education in Mental Health

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Objectives

The overall objectives of this program include the following: to provide continuing education activities for continuing educators in mental health settings and to encourage continuing educators to engage in a process of defining their own continuing education needs; to provide continuing education activities through which continuing educators may develop a greater understanding of adult learning theory and can test the impact of such understanding on the design of learning experiences for adults; to provide continuing education activities through which continuing educators can develop perceptions of the role of the continuing educator in mental health delivery systems; to provide continuing education activities through which continuing educators become aware and can test the contributions of continuing education activities to organizational development.

Methods and Content

Short-term educational experiences (10 hours-2 days) are provided. A group of potential participants assumes responsibility for designing the learning experiences and attempts to use innovative practices, primarily experiential in nature, for the participants' own learning, and thereby experiment with the use of such practices before application in the participants' own programs in their own mental health settings. The total group of trainees participates in planning for subsequent educational experiences as a part of each short-term experience. The nominal group process, with the group's representative to the planning committee serving as a group leader, is used as a first step in identifying learning needs and interests of the group.

One short-term educational experience entitled "Getting to Know the Adult Learner" has been planned and implemented with a group of 25 participants. Two followup learning experiences, "The Role of the Continuing Educator" and "Contributions of Continuing Education to Organizational Development," are planned for the 1972–73 academic year.

The group involved in previously described activities has participated in a special continuing education activity pertaining to the role of the coordinator (continuing educator) in the use of the Educational Telephone Network System. The ETN System is used monthly for sessions to help continuing educators plan for use of ETN programs in their own settings.

With the assistance of consultants from other States, a Summer Study Program on Rural Mental Health Services is being planned for June 1973. Educational responsibilities of rural mental health staff are being emphasized.

Students

All participants in the continuing educational activities for continuing educators have an assignment for continuing education, inservice education in their own mental health setting. Disciplines represented are: nursing (11), social work (4), personnel and training (3), psychology (2), occupational therapy (1), recreational therapy (1), clergy (1), and general liberal arts (2).

All participants are baccalaureate degree holders and have status and degrees in their own professional disciplines. The first group of participants are drawn primarily from institutional facilities. The second group of participants will have more frequent identification with centers and clinics and be more active in community adult education. Efforts have been made to stimulate interest and participation from adjacent States. Minnesota has had a representative in the series of short-term educational activities.

Program Evaluation

A system for program review has been established. The participants in the program engage in an evaluation process as a part of the design of the learning experience. Each participant in the program is engaged in an evaluation of program impact through completion of an impact analysis form. A representative group of participants serves as a planning committee for each continuing education activity, and the planning process requires evaluation of past activity and plans for evaluating the future activity. The department faculty serve as consultants to project staff in reviewing program development and activity.

The program activity can be replicated if the interests of continuing educators in other States or regions are similar to those of the group now participating. Continued attempts will be made to solicit participation from staff of adjacent States.

Participants in the current program are manifesting a more definitive identity as continuing educators. Administrative personnel are according greater clarity in organizational assignment to continuing educators. Project staff see a need to develop instruments to document such impressions.

APPENDIX

APPENDIX

Overview of Training Program

Please include brief statements in narrative form on the following questions. Also incorporate into your answers information on the *decisionmaking process* in planning and implementing your continuing education program (i.e., how are program decisions made and who makes them).

1. *Objectives*
   - a. General—identify overall continuing education objectives.
   - b. Specific—state specific objectives in terms of measurable knowledge, demonstrable skills or behavior change directed at specific needs (e.g., trainee target groups; mental health service priorities).
2. *Methods and Content*
   - a. Describe the training method(s) used in your program.
   - b. Delineate specific content areas.
   - c. Describe the time sequence and total course hours for each training activity.
3. *Students*
   - a. Identify the trainees represented in your program by discipline etc., and the number of students within each category.
   - b. Describe other significant characteristics (e.g., amount and nature of prior training; population of potential trainees).
4. *Program Evaluation*
   - a. Describe the method used for program evaluation. Include available data and future plans for evaluation. Who contributes to the evaluation process (i.e., personnel; trainees; consumers)?
   - b. What is the potential for replication of this program (or unique aspects of the program) at local, regional or national levels?
   - c. Describe the community, institutional or organizational impacts of the project to date.
   - d. List changes which have occurred in the program (e.g., training design) subsequent to submission of the most recent training grant application.
   - e. Briefly describe the major strengths and weaknesses of this project. Indictate why this program is an innovative approach to continuing education in mental health.
5. *Financing**
   - a. If your institution is now providing or plans to provide financial support for the program after termination of this grant, please indicate.
   - b. Identify other sources of funding (e.g., student fees; employer contributions; agencies).
   - c. Indicate the average cost per trainee day.

*Note: The Continuing Education Branch Staff determined that the responses to the questions under the section on Financing were not appropriate for this publication, and therefore deleted them from the summaries.

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